

# Gap Analysis of Gender-Based Violence in Humanitarian Settings: a Global Consultation

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We find solutions to complex humanitarian problems through research and innovation.

## ABOUT ELRHA

We are a global charity that finds solutions to complex humanitarian problems through research and innovation.

We fund and support work that goes on to shape the way in which people across the world are supported during a crisis. An established actor in the humanitarian community, we work in partnership with humanitarian organisations, researchers, innovators, and the private sector to tackle some of the most difficult challenges facing people all over the world. Our shared aim as collaborators is to improve the effectiveness of humanitarian response.

The innovations we fund through our Humanitarian Innovation Fund (HIF) target better outcomes for people affected by humanitarian crises by identifying, nurturing and sharing more effective and scalable solutions. We have supported more than 200 world-class research and innovation projects, championing new ideas and different approaches to find what works in humanitarian response.

# INTRODUCTION FROM ELRHA

In line with our strategic commitment to target the most pressing challenges in the sector and to ensure that innovation processes are evidence-based and problem-led, we commission robust gap analyses. These provide comprehensive and up-to-date overviews of the key issues, gaps and priorities within our different areas of focus. To date, this has included gap analyses for humanitarian Water, Sanitation and Hygiene (WASH), the Inclusion of People with Disabilities and Older People, and Gender-Based Violence (GBV). Based on this well-evidenced understanding of problems, we then explore where innovation has the potential to contribute to the solutions and, ultimately, to improve outcomes for people affected by crises.

Since 2015, we have dedicated resources, focus and support to innovation that tackles the complex and egregious problem of GBV in humanitarian settings. We have worked collaboratively with, and been guided by, key agencies and experts within the GBV

in emergencies community. In 2016, we published our first-ever GBV Gap Analysis in which key challenges across this sector were identified, evidenced and prioritised, and then transformed into opportunities for innovation. This Gap Analysis has contributed to the evidence base in the sector and is a foundational document that guides and informs our own Innovation Challenges, and our funded innovation portfolio on GBV.

We are now sharing with the sector our second Gap Analysis focused on GBV in humanitarian settings where 'gap' is defined as:

**'An area where new strategies are needed, where existing approaches should be improved or built upon and/or where further evidence is needed to assess the effectiveness of an approach.'**

Significant progress has been made by the community of practice since 2015. However, this Gap Analysis (while acknowledging that progress) seeks to update the outstanding and persistent gaps that continue to challenge the sector. It builds upon the first Gap Analysis, providing a further breakdown of how challenges, such as the need for quality GBV expertise or improved monitoring and evaluation (M&E) of GBV programming, manifest across different types of GBV programming. With this adaptation, we aim to present a wider breadth of gaps experienced across humanitarian GBV efforts and to increase the relevance of this report for more actors, such as non-GBV actors working to mitigate risks of GBV. Similar to the first Gap Analysis, this report identifies both operational and systemic challenges faced by the sector, continually acknowledging the complexity and diversity of needs across the sector in order to achieve its intended positive outcomes for women and girls in humanitarian settings.

# INTRODUCTION FROM ELRHA

This second Gap Analysis comes at a crucial moment for the GBV community of practice and the wider humanitarian sector. Amid a global pandemic with clear linkages to increasing cases of GBV, clarity on the related challenges faced by the sector and the risk mitigation, prevention and response activity required is more important than ever. While women and girls across the globe are facing heightened threats of GBV, the COVID-19 pandemic has placed additional responsibility and burden on an already strained and resource-poor sector. We therefore carefully adapted the methodology of the Gap Analysis to avoid any undue additional burden on, or risk to, any contributors to the report.

This latest Gap Analysis has been designed to have direct relevance to all those with a commitment and mandate to address GBV in humanitarian settings. Through its 'deep dive' into the gaps experienced across the various types of GBV programming, it provides a strong advocacy tool that is critical for this under-resourced area of work.

It provides clear direction for the many actors collectively working to address GBV – policy-makers, practitioners, donors, researchers and innovators - by highlighting the most pressing 'gaps', or areas of unmet need, which require our urgent attention and action.

Following this Gap Analysis, we will be commissioning a second phase of work aimed at ensuring that the voices of women, girls, and GBV practitioners in humanitarian settings are prominent and accurately represented. This will supplement the Gap Analysis' examination of the considerable existing bodies of data, work and research, drawing out the needs and insights directly identified by practitioners, women and girls. It will also tackle some of the COVID-19 related challenges we faced in directly accessing such views and opinions as part of the Gap Analysis research. This second phase of work will further explore and augment the findings of the Gap Analysis specifically from the perspective of women, girls and GBV practitioners in crises-affected settings, and will add further understanding and ownership of 'gaps' and needs from women and girls themselves.

The HIF will then strategically explore where innovation presents the greatest opportunity to positively impact the gaps to contribute to the prevention and mitigation of and the response to GBV in humanitarian settings. This will be in collaboration with the experts in our GBV Technical Working Group and will utilise the latest thinking from our own experience of effectively supporting humanitarian innovation. We will draw on learning from the wider humanitarian innovation community and the burgeoning community of practice of innovators specifically addressing GBV.

How each of us will mobilise ourselves and others to respond to the findings of this Gap Analysis will vary. However, it is clear that significant gaps remain. Whether further research is needed, or more flexible and adequate funding required - whether it's about improved accountability to women and girls, strengthening and/or mainstreaming of GBV programming, or developing and scaling innovative solutions - **this Gap Analysis demonstrates that we all have a role in the important work yet to be done.**

## ABOUT THE AUTHORS

This report was written by Maureen Murphy and Angela Bourassa of the Global Women's Institute (GWI) at George Washington University. Alina Potts and Manuel Contreras Urbina of GWI reviewed and provided inputs on the draft project design and report.

## ABOUT GWI

The Global Women's Institute (GWI) envisions a world where women and girls have the same rights and opportunities as men and boys and are free from discrimination, violence and coercion. GWI is a leading organisation that bridges research, education and action to advance gender equality and reduce violence and discrimination against women and girls. By strengthening the global knowledge base on gender issues and being a catalyst for change, GWI makes a difference in the lives of women at home and abroad. GWI finds interventions that work, explains why they matter, and takes action to bring about change.



## ABBREVIATIONS

**CBO:** Community-based organisation

**CEFM:** Child, early and forced marriage

**CHW:** Community healthcare workers

**CMR:** Clinical management of rape

**GBV:** Gender-based violence

**GBV AoR:** GBV Area of Responsibility

**GBVIMS:** GBV Information Management System

**HPC:** Humanitarian Programme Cycle

**HRP:** Humanitarian Response Plan

**IDP:** Internally displaced person

**IPV:** Intimate partner violence

**IASC:** Inter-Agency Standing Committee

**IMC:** International Medical Corps

**INGO:** International non-governmental organisation

**IRC:** International Rescue Committee

**LMIC:** Low-and middle-income countries

**MISP:** Minimum Initial Service Package

**M&E:** Monitoring and Evaluation

**MHPSS:** Mental health and psychosocial support services

**NGO:** Non-governmental organisation

**PSEA:** Prevention of Sexual Exploitation and Abuse

**PSS:** Psychosocial Support

**RTAP:** Real-Time Accountability Partnership

**SEA:** Sexual exploitation and abuse

**SRH:** Sexual and reproductive health

**UN:** United Nations

**UNICEF:** United Nations Children's Fund

**UNFPA:** United Nations Population Fund

**VSLAs:** Village savings and loans associations

**GSS:** Women and girls safe spaces

**WRO:** Women's rights organisations

**WHO:** World Health Organisation

## QUOTATIONS

All quotes in this report, unless otherwise attributed, are from primary research conducted by the Global Women's Institute at George Washington University.

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The Steering Committee, which comprised technical experts, academics and GBV practitioners, helped to guide this work at key stages of the development of the Gap Analysis. This included advising on the initial methodology; identifying opportunities for survey dissemination; navigating adaptations; and guiding the final prioritisation and classification of gaps experienced by the sector.

In addition, we thank all the humanitarian practitioners who took the time to complete surveys, supply documents and otherwise input into this product.

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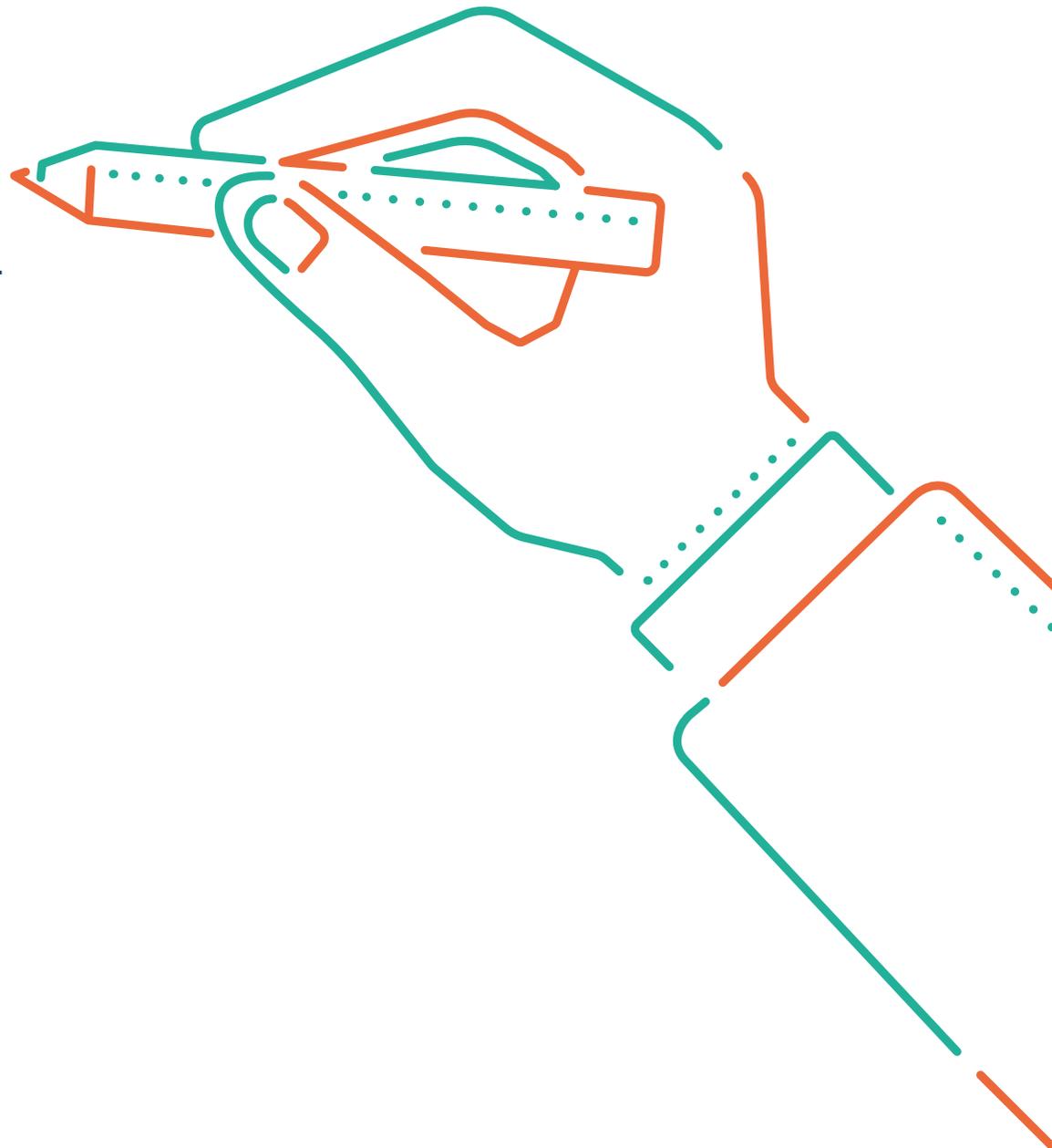
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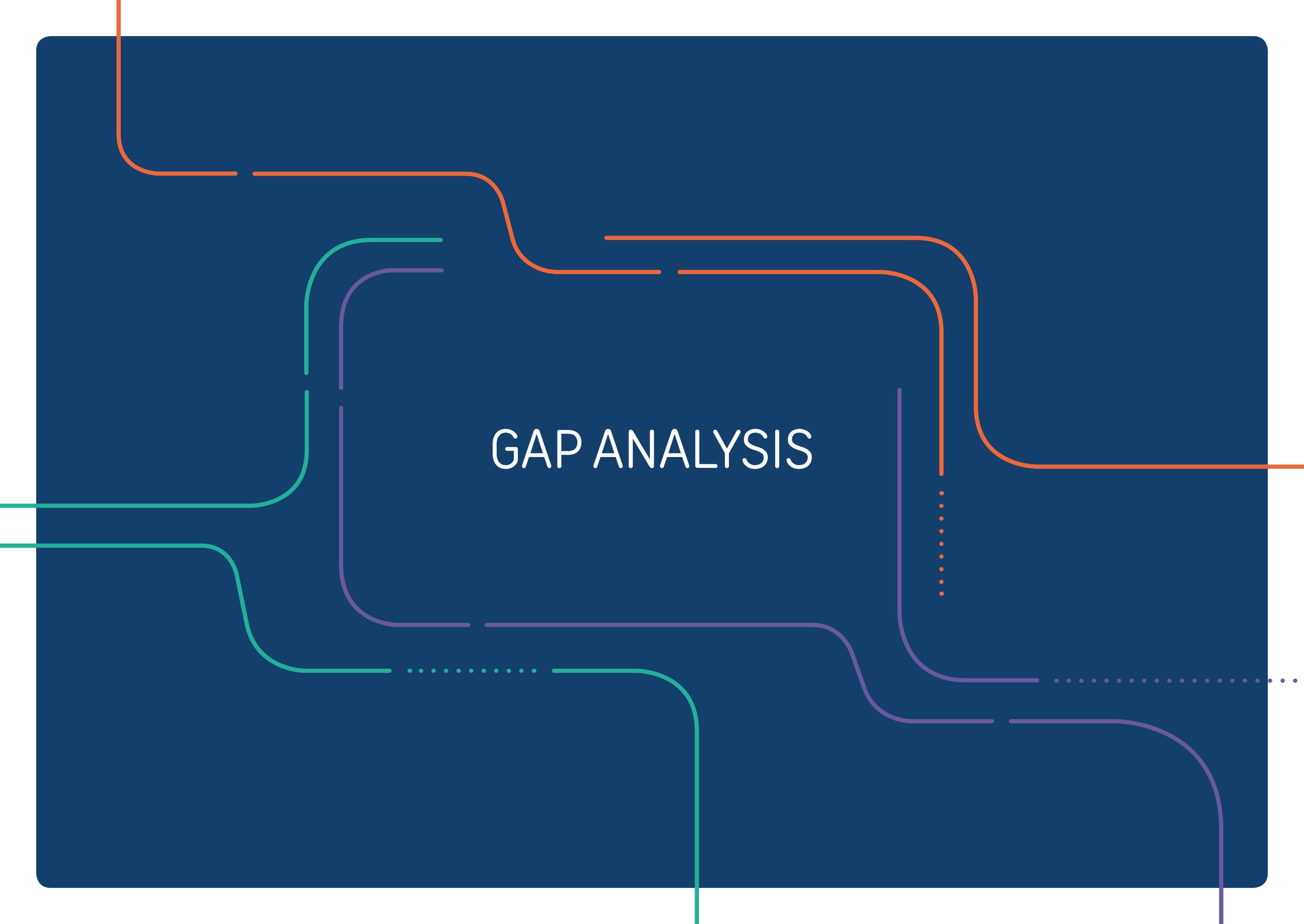


Ministry of Foreign Affairs



Norwegian Ministry of Foreign Affairs

# GAP ANALYSIS



# INTRODUCTION

## GBV in Humanitarian Settings

Gender-based violence (GBV) is 'an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty'.<sup>1</sup>

This violence may be perpetrated by intimate partners, family members (e.g. fathers, brothers, uncles) or others in the wider community (e.g. teachers, community leaders, employers, strangers, aid workers). Globally, an estimated one in three women and girls have experienced intimate partner violence (IPV) or non-partner sexual violence during their lifetimes, and millions are affected by other forms of gendered violence, such as child, early and forced marriage (CEFM), trafficking, and harmful traditional practices.<sup>2</sup> For women and girls in humanitarian crises, the risks of experiencing GBV often increase.<sup>3</sup>

The most common form of GBV affecting women and girls in humanitarian settings is IPV.<sup>4</sup> In fact, some studies have documented rates of up to three in four partnered women experiencing IPV in conflict-affected areas.<sup>5</sup> Increased poverty, lack of livelihoods, increased alcohol consumption, and the inability of men to fulfil what they see as their 'masculine' roles have all been documented as potential avenues that increase IPV in humanitarian settings.<sup>6</sup> Similarly, many of the identified drivers of IPV during and after armed conflict (e.g. poverty, displacement, stress and marital discord, alcohol abuse) within the home have been seen to increase after natural disasters, suggesting rates of violence also increase in these settings.<sup>7,8</sup> Women and girls are additionally at risk of increased violence as the global community faces the COVID-19 pandemic: with cases of IPV increasing in locations with movement restrictions and quarantine measures, as well as potential increases in rates of sexual exploitation and abuse (SEA) during public health emergencies.<sup>9,10</sup>

Many women and girls also experience sexual violence in humanitarian settings, with global estimates suggesting that about one in five refugee and displaced women report having experienced an incident of sexual violence.<sup>11</sup> In these settings, sexual violence may be employed as a weapon against women and girls, whether as a directed act as part of a military campaign or as an opportunistic event. In addition, sexual violence may also increase within homes and communities due to a variety of conditions including: displacement and security conditions in and around camps/settlements, breakdowns of social norms around violence, and limited rule of law/impunity of survivors.

# INTRODUCTION

Furthermore, other forms of GBV, while often receiving less attention than sexual violence and IPV, are also impacted by conditions in humanitarian settings. For example, girls may be married at a young age when families are unable to provide for their basic needs during a conflict or natural disaster. In addition, families may try to 'protect' their daughters by marrying them, if there is - or there is a perception of - an increased risk of sexual violence which could affect their virginity and thus marriageability.<sup>12</sup> Other patriarchal traditional practices (e.g. wife inheritance) and trafficking may also increase, due to displacement, lack of traditional social support structures, poverty and the breakdown of rule of law.

While high rates of GBV have commonly been reported in humanitarian settings, GBV has not always been recognised as a priority area for humanitarian action.

Considerable and sustained advocacy – at both global and country levels – has been, and continues to be, needed to increase awareness of the pervasive nature of GBV, and to ensure GBV programming is recognised as essential, and life-saving.

Furthermore, not all forms of GBV have been recognised equally and prioritised for action. For example, global attention has often been focused on non-partner sexual violence, due to a number of high-profile humanitarian crisis settings where sexual violence was a key feature, and establishment of the Women, Peace and Security Agenda (including UN Security Council Resolutions 1325 and 1820 among others). While these efforts heightened the profile of GBV in humanitarian settings, they also conceptualised GBV quite narrowly as sexual violence. Some donors and humanitarian actors continue to prioritise efforts to prevent and respond to sexual violence, leaving women and girls who experience other forms of violence that is considered to have 'pre-existed' the crisis left behind.

While sexual violence was often prioritised in global policy, practitioners working in humanitarian settings saw women and girls experiencing many different forms of GBV. Practitioners recognised and advocated for a more holistic approach to prevention and response work, and developed programming models to provide survivor-centred care to all women and girls who seek support, whatever the form of violence experienced.<sup>13</sup> Through this work, a more expansive definition of GBV was adopted by the humanitarian community - see the [Inter-Agency Standing Committee Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action](#) (the IASC Guidelines) - and there was increased attention on forms of violence such as IPV, traditional practices, and child, early and forced marriage (CEFM).

In the situational analysis section of this Gap Analysis, we delve further into the response of the humanitarian community to GBV.

# OBJECTIVES OF THE REPORT

## PHASE 1

To provide a systematic and comprehensive global assessment of GBV in emergencies.

To identify and prioritise evidence gaps and/or key needs to be addressed by the humanitarian community, including practitioners across all humanitarian action, donors, researchers, and innovators.

## PHASE 2

To further increase attention to the priorities of women and girls affected by crisis, and their recommendations to improve

# PURPOSE OF THE GAP ANALYSIS

Given the immense challenge of GBV in humanitarian settings, there is a need for responders to make use of their often-limited budgets to deliver effective programming to mitigate the risk of and prevent/respond to GBV. To this end, there is a need to identify what programmatic gaps and needs exist within the sector and to prioritise areas where further attention is needed in order to reduce GBV and better support survivors who have experienced violence.

The aim of the Gap Analysis is to provide a systematic and comprehensive assessment of GBV in emergencies within the framework of GBV risk mitigation, response, and prevention. It defines 'gaps' as 'areas where new strategies are needed, where existing approaches should be improved or built upon and/or where further evidence is needed to assess the effectiveness of an approach'. It incorporates the latest humanitarian GBV research, relevant findings and published standards, and extrapolates and prioritises gaps and key needs to improve humanitarian outcomes for women and girls affected by GBV.

To ensure that all objectives are met, **this work will be phased across two reports: this global consultation, and a second phase which will refine, validate and add to the global consultation, specifically from the perspectives of women, girls and GBV practitioners in crises-affected settings.**

The priority gaps identified within this report are relevant to many different actors within the humanitarian community. These will: inform practitioners in programmatic decision-making/design/prioritisation; inform targeted support needed from donors; provide clear direction to researchers to explore evidence gaps; and identify key areas of need for innovators to address through innovative solutions or processes.

# METHODOLOGY

A three-stage process was undertaken to create this Gap Analysis. First, to inform the situational analysis and help initially identify gap areas, a desk review of relevant recent research, standards and evidence related to GBV risk mitigation, response and prevention efforts in humanitarian settings was undertaken. For this process, 'humanitarian settings' were defined broadly and included differing phases of crises (e.g. rapid response, acute emergencies, protracted crisis), contexts (e.g. camps, urban locations), geography, environmental conditions, and types of crisis (e.g. including natural hazard-related disasters, conflict, or complex emergencies, either at the regional, national or sub-national levels, within LMICs).

We broadly followed the Inter-Agency Standing Committee's (IASC's) definitions of GBV set out in the **IASC Guidelines** and examined violence perpetrated by men and boys against women and girls on the basis of gender.<sup>14</sup> However, the decision was made to not include sexual harassment, exploitation and abuse (SHEA) in this report, as efforts to prevent, reduce risks and respond to these forms of violence are often unique work streams and, we believe, require separate analysis.

A search strategy was developed (including search terms and databases, and web repositories to search) to inform this review.<sup>15</sup> To complement this effort, targeted outreach was undertaken (e.g. through the GBV Area of Responsibility (GBV AoR) Community of Practice, ACT Alliance, the Localisation Task Force) to specifically request documents from operational agencies. We also searched for both grey and peer-reviewed literature to ensure the full scope of ongoing efforts was documented. This included incorporating recent findings from the **What Works** programme, reviewing response documents such as Humanitarian Response Plans (HRPs) and Needs Assessments, and examining global standards, such as the recently released **Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming** (the new GBV Minimum Standards). A total of 241 documents were initially identified through this process. Data from these documents was then extracted and compiled into 276 individual records (a document could be split into multiple records if, for example, it covered both response and prevention activities), which were then tagged and coded by type of approach.

Through the review, we worked to identify what evidence currently exists and what support is still needed by practitioners to improve their service delivery in terms of risk mitigation, response, and prevention programmes. Secondary data analysis was undertaken, using the materials uncovered through the literature review and existing datasets available to the Global Women's Institute, in order to incorporate the perspectives of women and girls. While we had initially hoped to have more in-depth engagement with women and girls themselves, the outbreak of COVID-19 limited our ability to travel and to collect primary data in crisis-affected settings.

# METHODOLOGY

The project team synthesised the results of the desk review, documented preliminary findings and identified an initial list of potential gap areas. However, we recognised that our analysis may have been affected by publication biases (i.e. successful programmes are more likely to be written about) and the fact that larger, more well-resourced organisations are often more likely to document and publish about their programming which may have affected our analysis. To supplement this and triangulate the information emerging from the desk review, global consultations through a virtual survey were circulated to humanitarian professionals and through the 2020 **Call to Action** Annual Partner's Meeting Virtual Forum. These consultations enabled us to hear from frontline and headquarters-based humanitarian actors - including international non-governmental organisations (INGOs), local non-governmental organisations (NGOs), women's organisations, and donors - about gap areas based on their own experiences and perspectives.

The results of the review and consultations were initially sorted into three areas: GBV prevention; response; and risk mitigation (programmes with multiple components were repeated in each relevant area). Within each of these wider classifications, the research team then read through the documentation

and created broad classifications by programme type (e.g. health response, psychosocial response, legal response, case management) based on the programming models that were identified.

Programming models were then reviewed utilising the following criteria: strength of programming design (i.e. if programming models were based on evidence, theory, or drew on best practices agreed to by the humanitarian sector); reach (i.e. programming targeting differing population groups including by age, urbanity, camp versus non-camp); and demonstrated effectiveness of the programming approaches (i.e. academic or anecdotal evidence suggesting that the programming was effective). The documented programming models were also assessed against the global guidance documents available from the GBV AoR and other inter-agency mechanisms to identify any areas where no programming existed at all. This process led to an initial list of 85 potential gaps being developed.

The project team then worked to build consensus on priority evidence gaps and key needs through a systematic process utilising a modified Delphi technique.<sup>16</sup>

The Delphi technique entails rounds of questions being posed to global and

country-level specialists. Given our interest in engaging a wide range of stakeholders to represent a broad and global swathe of contexts, experiences, knowledge and skills, we kept the engagement at a wide level throughout the process. This pragmatic approach enabled us to build knowledge that incorporates diverse perspectives (e.g. 'medical', 'expert', 'lay' knowledge), and also ensure that the knowledge can be used for action and decision-making.<sup>17</sup>

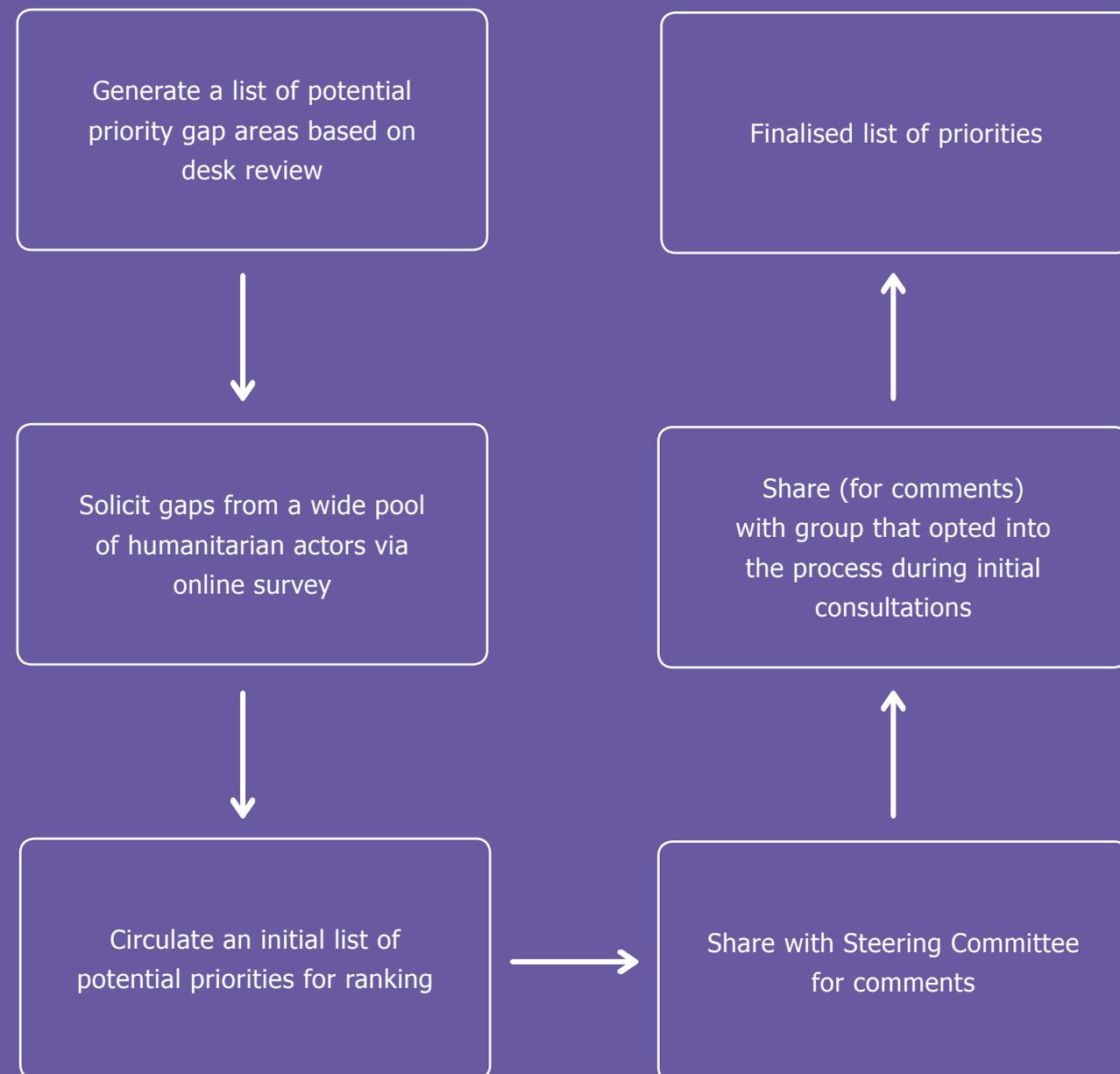
To ensure wide engagement and buy-in, the initial ranking exercise was shared widely with the humanitarian community broadly (including with the online GBV Community of Practice) who were asked to rank their priorities. Ninety-three respondents participated in this exercise, representing INGOs (40%), National NGOs or community-based organisations (25%), the UN (25%) and others including donors and academics (10%). 70% of respondents reported that they were GBV staff, and 9% were from general management. About half (55%) were working at national offices (32%) or sub-national (23%) offices in humanitarian settings.

# METHODOLOGY

Once this initial ranking had been completed, the list was shared and validated with a smaller group of experts who served as the Steering Committee for this process. They reviewed the draft list of prioritised gaps, and made suggestions to refine the wording of the list. They also suggested possible changes to the final ordering, based on their expert knowledge.

There was then a second round of validation and edits to the ranking. This was carried out with a smaller group of humanitarian practitioners who had, during a previous survey round, indicated their interest in staying engaged and informed throughout the prioritisation process. An initial list of ranked priorities was shared with this group, and participants were able to make changes and suggest edits to the final ordering. A total of 53 respondents took part in this stage of the process. Almost 40% of these participants reported they worked for a national NGO or community-based organisation (while 27% were from INGOs and 18% from UN agencies) and the majority (60%) were GBV staff.

Figure 1: Steps of the prioritisation process:



# METHODOLOGY

The final list of gaps was then categorised as areas where: 1) new strategies are needed; 2) existing strategies should be built upon and/or improved; and/or 3) evidence is needed to demonstrate the effectiveness of existing strategies.

Most identified gaps could have been classified in multiple categories. For example, improved evidence of effectiveness could be relevant for almost all of the stated gaps. However, in order to improve the utility of the report, we aimed to classify each of these in accordance with the biggest or most important gap areas. We sought input from the humanitarian community, the Steering Committee and our own assessment based on the situational analysis to make these final classifications. This participatory and collaborative process sought to build co-ownership of the knowledge created across a broad swathe of actors operating at country and global levels. This would support consensus and buy-in on the key gaps, as well as agreement on where further work is needed to support uptake of the Gap Analysis' findings. Finally, this would garner support for the upcoming work of the HIF to follow on from this Gap Analysis, as well as for the wider international community's response to it.

Due to the COVID-19 crisis, which emerged as a global pandemic during the planning phase for the consultations to inform the Gap Analysis, initial plans for direct, in-person consultations with women and girls and humanitarian practitioners had to be revised. The original methodology had envisioned the use of wide in-person and virtual consultations, and in-depth case studies in humanitarian settings. As the work began, however, the global pandemic accelerated and the programme of work had to be modified to ensure the process was undertaken in a responsible and ethical manner. In consultation with the Steering Committee, a new approach was devised that prioritised virtual consultations and secondary data analysis. Disruption to international travel prevented expected travel for case studies and for global consultation events. In addition, many GBV specialists and other global experts who we originally planned to engage were pulled into COVID-19 response – creating modified programme delivery mechanisms to ensure the women and girls are able to access services even the midst of stay-at-home orders and other movement prohibitions.

Given the worldwide global spikes in GBV amidst this crisis, we aimed to employ a 'light touch' consultation approach. We used fully virtual means for primary data collection and prioritisation, through a process where recipients could 'opt-in' to the process as their work schedules and priorities allowed. However, this adaptation did limit the participation of some community-based organisations (CBOs) and other frontline service providers, as well as women and girls themselves, who do not have internet access or were not on the global listservs through which the consultation surveys were distributed.

Nevertheless, secondary data analysis of previous consultations with women and girls was possible, and a quarter of respondents to the virtual survey worked from local NGOs or CBOs, so these stakeholder groups did greatly inform the gaps areas identified in this report. To ensure that the voices and lived experiences of women, girls and practitioners in humanitarian settings remain at the forefront of this work, the HIF plans to support a second phase of the Gap Analysis in 2021, where the findings from this report can be refined, validated and added to, specifically from the perspectives of women and girls themselves.

# SITUATIONAL ANALYSIS

All GBV is rooted in patriarchal gender norms and inequitable power dynamics.

Interventions to address this violence (whether risk mitigation, prevention, or response) need to recognise and/or be designed to change these dynamics. However, GBV programming is situated in a humanitarian aid system built on inherent power imbalances (between

displaced people and host communities, aid workers and the affected populations, international and national staff, staff and volunteers or incentive workers, etc.). In this section, we will provide an overview of the existing landscape of GBV coordination and programming, documenting the efforts made to improve the situation for women and girls living in humanitarian settings. This analysis has informed the identification of operational and systemic gaps (explored from [page 41](#)) that indelibly impact the structure and implementation of effective GBV programming.

## Guidelines and Support Documents for Specific Contexts

[Strengthening GBV Prevention & Response in Urban Humanitarian Contexts: Building Capacity Across Cities](#)

[Mean Streets: Identifying and Responding to Urban Refugees' Risks of Gender-Based Violence – LGBTI Refugees](#)

[Protecting Women and Girls and Ensuring Access to Services](#)

## Key Guidance Documents for GBV Programming in Humanitarian Settings

There are a number of essential documents that provide overall guidance for GBV practitioners and stakeholders in other sectors seeking to mitigate the risk of GBV in their own work. These include:

[The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming](#)

[Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action](#)

[The GBV Accountability Framework](#)

[The Gender Handbook for Humanitarian Action](#)

[Handbook for Coordinating Gender-based Violence Interventions in Emergencies](#)

# SITUATIONAL ANALYSIS

## Global GBV Humanitarian Response

The global humanitarian system has multiple structures to coordinate and support the work of GBV risk mitigation, response and prevention in humanitarian crisis. These include the IASC, the Global Protection Cluster and the **GBV AoR**. High-level initiatives, such as the **Call to Action on Protection from Gender-based Violence in Emergencies**, have brought together governmental donors, international organisations, and NGOs to advocate that GBV is prioritised from the earliest stage of a crisis. The 2013 IASC Principals' Statement on the Centrality of Protection in Humanitarian Action has mandated that all humanitarian activities are to be protection-oriented and seek to prevent, mitigate or end risks to the affected population.<sup>18</sup>

Likewise, protection for and accountability to the affected populations have been highlighted as key considerations to be integrated throughout the Humanitarian Programme Cycle (HPC) including the development of the needs overview, response planning, and implementation/monitoring.<sup>19</sup> Key guiding documents for the humanitarian community, such as the **Sphere Handbook**, highlight the importance of prioritising the safety of women and girls and incorporating GBV risk mitigation and response activities throughout humanitarian response.

However, despite these advances, support and resources to address GBV remains limited.

Systemic challenges within the humanitarian system prevent the prioritisation of GBV at global and country levels and there is limited understanding of what GBV is or what an appropriate GBV response in a humanitarian setting should look like.<sup>20</sup> These issues can be seen in the lack of GBV activities or indicators incorporated into other sectors' HRPs, and a lack of funding for GBV programmes. For example, examining the last five years of financial tracking data for humanitarian funding, less than 1% of funding was allocated to the GBV sector.<sup>21,22,23</sup> In addition, the funding gap for GBV programmes is consistently wider than those of other sectors. In 2019, of the 16 other sectors where funding was tracked by the Financial Tracking System, 13 had larger proportions of their appeal funded compared to the GBV sector.<sup>24</sup> While these are only a few examples, they point to a consistent de-prioritisation of the GBV within humanitarian action.

The image features a solid orange background with a central white-outlined rectangular box containing the text "RISK MITIGATION". This central box is surrounded by a complex, symmetrical pattern of white lines. These lines consist of solid segments and dotted segments, creating a stylized, circuit-like or architectural feel. The lines extend from the central box towards the edges of the frame, with some segments ending in dots. The overall composition is balanced and modern.

RISK MITIGATION

## Risks of GBV – perspectives of women and girls

“Sometimes when you have a grass thatched toilet, they push it down. When there’s a village occasion, these young boys become unruly and starting spoiling things around them and can even beat us.”

**Woman – Uganda**

“During the day, the latrines are very safe, but after dark there is a real threat of being attacked.” **Woman – Oxfam Research Nigeria**

“It’s a long way from where I live to the distribution center, so I will need to take a taxi which may not be safe for a girl of my age, even for older woman. If my mom goes, the situation will be similar for her too. The distribution center is very crowded so I may get robbed or harassed.”

**Adolescent girl – Lebanon**

“Rape also takes place, this mostly happens when women go to collect firewood.” **Woman – Uganda**

“A girl is not allowed to walk at night because it’s not safe for girls.”

**Adolescent Girl - Plan International Research Nigeria**

“When women go out at night [to the distribution point] to be the first in line, men were sleeping down and waiting for us. They surrounded us. They have guns, knives, sticks and pangas.” **Woman – South Sudan**

## RISK MITIGATION

GBV risk mitigation activities aim to ‘reduce the risk of exposure to GBV (e.g. ensuring that reports of ‘hot spots’ are immediately addressed through risk-reduction strategies; ensuring sufficient lighting and security patrols are in place from the onset of establishing displacement camps; etc.).’<sup>25</sup> A multi-sectoral approach (i.e. engaging multiple sectors within humanitarian action to provide holistic services to survivors)<sup>26</sup> is encouraged. This emphasises the roles and responsibilities of the entire humanitarian sector to reduce the risks of violence that are faced by women and girls and is highlighted in the key guiding document for mitigation activities – the **IASC Guidelines**. Mitigating risks entails delivering humanitarian aid that: 1) does not cause or increase the likelihood of GBV; 2) proactively facilitates and monitors vulnerable groups’ access to services; and 3) is responsive to GBV risks in the environment.<sup>27</sup> Importantly, risk mitigation activities are often undertaken by non-GBV specialists (or at least non-GBV specialists exclusively) as the work of identifying and mitigating the risks of violence needs to occur within every sector during humanitarian action.

Much of the guidance laid out in the IASC Guidelines focuses on ensuring that programming is designed to be gender-responsive and considers risks for women and girls throughout programme design and implementation. In order to identify risks and inform the development of mitigation programming, assessment activities, (e.g. safety audits and safety/risk mapping), can be undertaken as part of a multi-sectoral or individual sector approach to risk identification and mitigation. Most of these approaches utilise a combination of observational checklists to assess the physical layout/condition of a space, as well as interactive discussions or walks with women and girls themselves to identify risks from their perspectives. While the IASC Guidelines note that global positioning systems (GPS) can be utilised – particularly by practitioners to confidentially identify potentially unsafe areas where intervention is needed – there is no indication that this is commonly used, even though there is a proliferation of mobile data collection devices that include GPS functionality.

# RISK MITIGATION

Risk mitigation activities that are implemented are often relatively quick and simple interventions that target high-risk areas where the humanitarian community knows that violence is likely to occur. For example, the installation of solar lights in high-risk areas (e.g. latrine and shower areas) or the prioritisation of women-headed households for shelter distributions. Gender mainstreaming and GBV risk mitigation was included as central to shelter activities after Typhoon Hagupit (Ruby) in the Philippines. This included distributing shelter repair kits to women and children, cash grants to support shelter activities and technical support.<sup>28</sup> Similarly, Safe Access to Firewood and Alternative Energy (SAFE) approaches support women to have safer access to cooking fuel. These include firewood distribution schemes, programmes where women gather firewood together with guards or where patrols are set up to monitor areas where firewood is collected, and fuel-efficient cook stoves that reduce the amount of firewood needed, or cook stoves that use other sources of energy (e.g. kerosene, biogas).

There is some empirical evidence of the effectiveness of these approaches. For example, a solar light project in refugee camps in Uganda found the likelihood of 'bad' experience five times higher in unlit locations

at night compared to areas with lights,<sup>29</sup> and safe firewood programmes have been documented to reduce incidences of sexual violence when implemented in refugee camp settings.<sup>30,31</sup> Case studies have explored how building the capacity of and supporting frontline practitioners can have concrete impacts on improving risk mitigation activities within different sectors.<sup>32</sup> Overall, however, there have been few evaluations that have systematically evaluated the effectiveness of risk mitigation actions, and the available academic evidence supporting the effectiveness of these actions is quite weak. The limited scope of these interventions may also hinder wider-scale impact. For example, in a solar lamp distribution project in post-earthquake Haiti, while women were appreciative of the lamps and used them regularly, the lamps did not improve their sense of safety, as their wider safety concerns (e.g. generalised violence, crime, lack of security forces, more secured shelters) were not addressed through this programme.<sup>33</sup> Furthermore, distributing supplies such as solar lights only to women may increase safety concerns as they may then be seen to have valuable assets that men do not have access to.

## Risk Mitigation and COVID-19

In light of the ongoing COVID-19 pandemic, specific guidelines have been developed to support the continuation of risk mitigation activities, given the unique circumstances that the pandemic has created (e.g. stay-at-home orders, social distancing) and its impact on rates of IPV and violence within the home. See for example:

[IASC's Identifying & Mitigating Gender-based Violence Risks within the COVID-19 Response](#)

[ICRC's Prevention and Response to Sexual and Gender-Based Violence in COVID-19 Quarantine Centres](#)

[Guidance on Establishing Remote Monitoring and Management of GBV Programming in the Context of the COVID-19 Pandemic](#)

[UNICEF's Responding to the Shadow Pandemic](#)

In addition, an overall compendium of the tools and resource can be found: [GBV AoR Tools and Resources for COVID-19](#)

## RISK MITIGATION

Risk mitigation activities are also often focused in 'traditional' humanitarian settings such as in refugee camps, and there has been limited work in non-camp locations - particularly urban settings. Even within camps, risk mitigation activities often do not address all potential risks that women and girls may experience. For example, while solar lights can be helpful to reduce risks in high-traffic areas of a camp, there are still many areas of the camp that are not reached by these lights. The limited scale of these programmes may limit the overall effectiveness of these approaches.

Identified risks and associated mitigation activities often focus on the built environment and mitigating physical risks (e.g. gender segregated latrines, lighting, location of water points). Less attention is paid to identifying and mitigating risks beyond these simple and easy-to-employ measures. One exception to this is the efforts of the humanitarian community to learn about the potential risks and mitigation approaches of distributing cash programming in humanitarian action. Research has shown that distributing cash,

even in emergency settings, can have unintended consequences, such as increasing IPV.<sup>34</sup> This does not mean that cash should not or cannot be distributed safely in humanitarian settings. It does, however, highlight the importance of considering the needs of women and girls throughout the design, implementation and monitoring/evaluation of any cash programme, and best practices on reducing the risks of harm incorporated throughout.<sup>35</sup> Furthermore, while some ongoing programmes are seeking to document and address inherent power dynamics within the humanitarian aid system – particularly those contributing to SEA - in order to reduce the risks women and girls may experience when interacting with this system (see for example, the **Empowered Aid programme**), **more attention is needed to fully integrate risk mitigation and to go beyond the minimum.**<sup>36</sup> Initiatives, such as gender-segregated latrines and locks on doors are important. But in and of themselves they are not enough to fully mitigate the risks women and girls experience in humanitarian action.

One important component of risk mitigation activities is the participation of not only humanitarian aid workers, but also members of the affected communities themselves. Women and girls are often consulted during the process of identifying risks, and the use of participatory approaches such as safety walks can bring in differing sub-sets of the population who can help identify risks as well as mitigation strategies.<sup>37,38</sup> While less commonly employed, women and girls are sometimes engaged more fully through the process of implementing the risk mitigation activities. For example, selecting solar lights and identifying appropriate locations where they will be installed.<sup>39</sup> Overall, women and girls appear to be less consistently engaged in developing approaches to mitigate risks, monitoring, and ensuring that risk mitigation activities are effectively implemented.<sup>40</sup>

“Many people come and interview us about our ideas and our conditions – we always share them. But when we get assistance, nothing changes ...international NGOs, thank you for the work you do, but sometimes you come with solutions that you don't get from the people”

**Women – Oxfam Research in South Sudan**

## RISK MITIGATION

Despite considerable efforts to galvanise the humanitarian community to prioritise risk mitigation, challenges remain. Gender-based violence risk mitigation activities are still often seen as under the remit of the GBV sector, rather than fully integrated in the work of all sectors. This stems not only from a lack of capacity of non-GBV specialists to identify and act to reduce potential risks, but also a lack of prioritisation and defined responsibility to take these actions. Some of these gaps can be structural in nature. For example, flexible funding to take action in response to issues identified by safety audits or funding streams that co-fund sectoral and GBV risk mitigation activities in a holistic package is not always available. This may limit the effectiveness of the group to advocate for GBV priorities within the wider humanitarian system.

However, other deficiencies in implementing these activities are due to lack of commitment of other sectors to prioritise GBV activities, and a lack of accountability to ensure that these activities occur. Initiatives such as the **Real-Time Accountability Partnership (RTAP)** are working to increase

accountability throughout the humanitarian community, though this effort has not yet been widely rolled out. In addition, there is limited evidence to assess if these existing risk mitigation approaches are having an impact – particularly from the perspective of women and girls themselves. New initiatives, such as the United Nations Children’s Fund’s (UNICEF’s) efforts to measure the effectiveness and outcomes of GBV risk mitigation activities by measuring both safety perceptions and sector-specific outcomes, and the Empowered Aid programme’s adaptation of existing distribution monitoring tools to better capture safety and risk in relation to SEA, are promising approaches that seek to standardise both the way risk mitigation is understood and measured, and the way aid agency staff are equipped to analyse and apply their findings to creating safer programming.<sup>41,42</sup> However, more needs to be done to increase mainstreaming, accountability and the effectiveness of current approaches.

“Sexual violence, child rape and harassment at school, to the extent that she feels afraid of sending their daughters to school.”

**Woman – Voices of Syria**

# KEY RISK MITIGATION SUPPORT DOCUMENTS

## GENERAL

[CARE's Rapid Gender Analysis Toolkit](#)

[UNICEF's Safety Audit How-To Guide](#)

[IRC's Emergency Assessment Tools](#)

[GBV AoR Tools & Resources for Thematic Areas](#)

## CAMP COORDINATION AND CAMP MANAGEMENT

[Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Camp Coordination and Camp Management](#)

[Camp Management Toolkit \(Chapter 10 – Gender-based Violence\)](#)

[Why Does Gender Equality Matter in Emergency CCCM Interventions?](#)

## CASH AND VOUCHERS

[Assessing and Mitigating Risks of Gender-based Violence: Guidance for Cash Providers](#)

[Cash & Voucher Assistance and Gender-Based Violence Compendium: Practical Guidance for Humanitarian Practitioners](#)

[Cash and Voucher Assistance \(CVA\) and market-based approaches in COVID-19](#)

## CHILD PROTECTION

[Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action – Child Protection](#)

[The Alliance for Child Protection in Humanitarian Action – Technical Note: Protection of Children during the Coronavirus Pandemic](#)

## EDUCATION

[Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action – Education](#)

[Guide to Coordinated Education in Emergencies Needs Assessments and Analysis](#)

[Considerations for Protection Against Sexual Exploitation and Abuse & Gender-based Violence in Education in Emergencies Needs Assessments](#)

[Briefing note: Education programming and Gender-based violence risks](#)

[INEE Minimum Standards for Education: Preparedness, Response, Recovery](#)

## FOOD SECURITY AND AGRICULTURE

[Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action – Food Security and Agriculture](#)

# KEY RISK MITIGATION SUPPORT DOCUMENTS

## HEALTH

[Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action](#)  
- [Health](#)

## HOUSING, LAND AND PROPERTY

[Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action](#)  
- [Housing, Land and Property](#)

## HUMANITARIAN MINE ACTION

[Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action](#)  
- [Humanitarian Mine Action](#)

## LIVELIHOODS

[Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action](#)  
- [Livelihoods](#)

## NUTRITION

[Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action](#)  
- [Nutrition](#)

## PREVENTION OF SEXUAL ABUSE AND EXPLOITATION

[Summary of IASC Good Practices: Preventing Sexual Exploitation and Abuse and Sexual Harassment and Abuse of Aid Workers](#)

[Interim Technical Note: Protection from Sexual Exploitation and Abuse \(PSEA\) during COVID-19 Response](#)

[CHS Alliance - PSEAH Implementation Quick Reference Handbook](#)

[CHS Alliance - PSEA Handbook Additional Resources](#)

[Safeguarding Resource and Support Hub](#)

## PROTECTION

[Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action](#)  
- [Protection](#)

## SHELTER, SETTLEMENT AND RECOVERY

[Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action](#)  
- [Shelter, Settlement and Recovery](#)

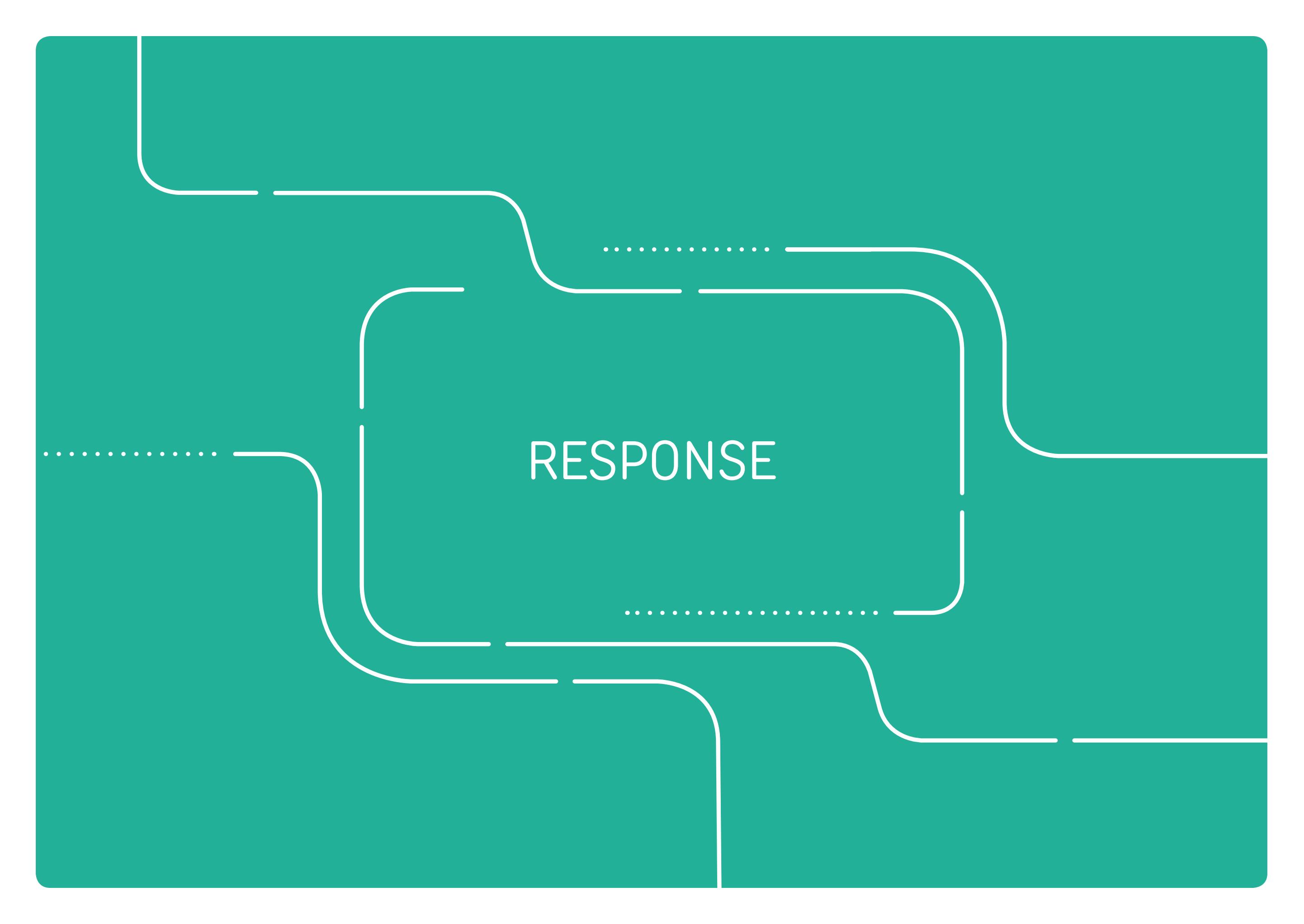
[Global Shelter Cluster's GBV Constant Companion: GBV in Shelter Programming Working Group](#)

[Site Planning: Guidance to Reduce the Risk of Gender-Based Violence](#)

## WATER, SANITATION AND HYGIENE

[Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action](#)  
- [Water, Sanitation and Hygiene](#)

[WASH Minimum Commitments to Safety and Dignity](#)



RESPONSE

## RESPONSE

### Accessing GBV response services – perspectives of women and girls

“Maybe what I can say is the referral pathways, because you find that at some point you would like to refer a client to a certain organisation for her to receive more help, but you find that the response is not immediate ... you may find that she comes back saying that they haven’t been helped ... or that there were other challenges ... That is the key limitation I can remember.”

#### Woman – What Works Dadaab Study

“As long as you are married off to that man and have children you are not supposed to go to the police. Your husband will still beat you. Your husband will say, you go and marry the policeman.”

#### Woman - South Sudan

#### **Accessible, survivor-centred services to support women and girls in the aftermath of an incident of violence are an essential component of GBV programming in humanitarian settings.**

Survivor-centred approaches aim ‘to create a supportive environment in which each survivor’s rights are respected and in which the person is treated with dignity and respect’.<sup>43</sup> Inter-agency guidance and international best practice has highlighted the importance of approaching response efforts in a manner to facilitate informed decision-making and agency of survivors. This is typically operationalised through a case management process that informs survivors about the services that are available and supports their ability to access health, legal, protection and other specialised services (‘the referral pathway’). Each component of this referral pathway should also embrace survivor-centred principles and practices.

Response programmes often rely on, or may be integrated into the work of, governments – even in humanitarian settings. Referral pathways generally rely on some government-provided services (police, legal, and in some settings health care). As such, while GBV programmes may work closely with local or national government actors to mitigate risks of GBV or establish prevention campaigns, this linkage is often most fully realised as part of GBV response activities. Generally, this work includes efforts such as developing national or local GBV protocols, establishing minimum standards for quality care and standard operating procedures (SOPs) for actors along the referral pathways. These efforts often begin in the acute phase of an emergency but build and develop over time, particularly during the transition to early recovery and/or return (as relevant).

# RESPONSE

However, despite the essential nature of response services, the lack of funding and the overstretched capacity of the sector affects the prioritisation and provision of services. For example, in 2019 there was a 90% gap in the funding needed to implement GBV programmes in Nigeria, according to an analysis undertaken by the GBV sub-cluster. This resulted in GBV programming that reached only 34% of the population at risk, and targeted functional referral pathways in only 16 of the targeted 65 local government areas.<sup>44</sup> Similarly, only 20% of at-risk women were reported to have access to GBV services in South Sudan in the 2020 Humanitarian Needs Overview (HNO).<sup>45</sup> Furthermore, these statistics only reflect access and do not attempt to assess the quality of available services, which is often low in these settings. As described by a respondent in the global consultations for this report, “In many humanitarian settings the provision

of GBV services is incredibly limited, with organisations that do provide GBV response often providing very limited services. In many contexts we see ‘circular referrals’, with GBV specialist organisations providing GBV awareness-raising, psychosocial first aid and referrals - and everyone referring to each other with no one really providing services.”

In order to explore the multiple components of response services, typical components of GBV response programming and referral pathways will be detailed on the following pages, in brief.

Despite the essential nature of response services, the lack of funding and the overstretched capacity of the sector affects the prioritisation and provision of services.

# RESPONSE

## Case Management

Case Management is 'a structured method for providing help to a survivor. It involves one organisation, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them and that issues and problems facing a survivor and her/his family are identified and followed up in a coordinated way, and providing the survivor with emotional support throughout the process.'<sup>46</sup>

Within the community, women and girls often become aware of response services through peer educators or other community-based mechanisms that work to raise awareness about GBV and act as first points of contacts for women and girls who may need services. In addition, Women and girls safe spaces (WGSS) often act as a point of entry to the case management/referral system, where counselling and other support is given to survivors.

Case managers (often social workers themselves or staff who have undergone on-the-job training and who work under a social worker) are the key workforce

supporting women and girls through the case management process. In some contexts, as part of efforts to shift tasks to be directly delivered by displaced persons themselves, or due to a lack of availability of trained social workers, community-based workers also supplement and provide case management services. However, this can result in mixed quality of service. For example, recent research on task-shifting within the context of case management services found that refugee community workers were generally acceptable to survivors, and a majority of survivors interviewed found their interactions with these community workers to be helpful, though there were concerns about capacity, confidentiality, etc.<sup>47</sup>

While the majority of case management programmes are tied to static locations (WGSS, health clinics, shelters, etc.), there are also some examples of mobile service delivery of GBV response services, often to complement what is offered in static centres. Mobile services can involve teams travelling periodically to locations where they provide non-stigmatising activities (e.g. skills building, health care) while at the same time

allowing space for women to disclose cases and enter the case management system.<sup>48</sup> In addition, fully remote case management services (delivered via mobile hotlines, chat or SMS) have also been seen to be feasible and acceptable in populations that have piloted these approaches.<sup>49</sup> Based on lessons learned from this emerging field, specific guidelines to support mobile and remote GBV service delivery have been developed.<sup>50</sup>

One success of the global GBV community is the establishment of standardised forms and processes to collect and confidentially share de-identified data through the **Gender-Based Violence Information Management System** (GBVIMS) and GBVIMS+/Primer systems. Evaluations of the GBVIMS have found that it successfully facilitated safe data sharing, coordination and evidence-based decision-making.<sup>51</sup> In addition, GBVIMS+/Primer has expanded its capability to support case management data, as well as tracking incidents of violence. However, there have also been controversies around data collection and safe data sharing - particularly with donors requiring access to individual survivor information and/or requiring survivors to participate in specific

response activities no matter the survivor's interest - unethical practices that can put those individuals at increased risk.<sup>52</sup> These examples demonstrate that while donors can have an effective role in promoting accountability and highlighting GBV issues, their role should be to support GBV specialists to provide confidential and survivor-centred services, and not to require access to confidential data or to intervene in direct service provision.

“Women keep silent about the violence they face, for fear of shame. There are no rules that protect women.”

**Woman – Voices of Syria**

# RESPONSE

## Mental Health and Psychosocial Support (MHPSS)

Closely linked to case management services are psychosocial support (PSS) efforts. As laid out in the MHPSS framework for interventions (see Figure 2), MHPSS interventions can target different needs – from generalised support, to specialised services.<sup>53</sup> The most specialised services are targeted mental health counselling for specific disorders (e.g. PTSD, depression) that occur as a result of an incident of GBV. However, the majority of survivors of violence are able to recover after the re-establishment of basic security and basic services and with the support of family and/or friends. Additionally, focused and non-specialised support, such as activities delivered through WGSS, gives space for informal social support and community and can provide opportunities to build skills, share knowledge and engage in recreation activities. While these WGSS are typically physical spaces located within the community, virtual safe space models are also emerging as an alternative mechanism

to provide information related to health and safety and an opportunity to connect with service providers in contexts where women and girls are unable to physically access space.<sup>54</sup>

WGSS can also act as an entry point for survivors who need case management or other support services as well as provide space for on-going counselling or support. Other PSS models that are emerging as potential avenues for further exploration include 'self-help' programming models, which are brief and low-intensity interventions, relevant across a wide range of people and settings.<sup>55</sup> Peer support networks/groups aimed at supporting specific sub-groups such as adolescent girls have been organised as a means to build community support.

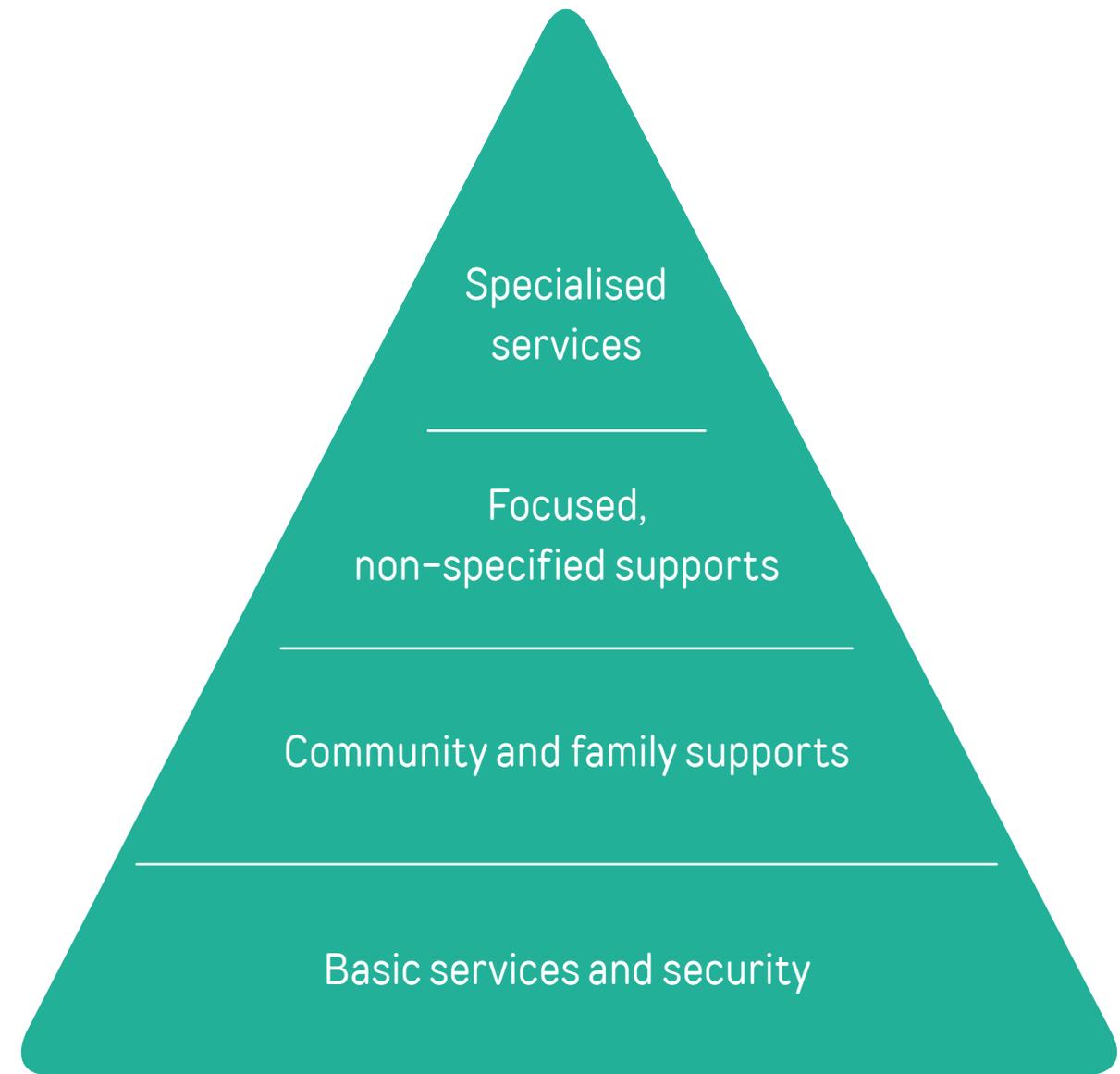


Figure 2: MHPSS framework for interventions

# RESPONSE

## Mental Health and Psychosocial Support (MHPSS)

In addition, skills training, livelihoods, cash transfers and other savings and loan programmes (e.g. village savings and loans associations (VSLAs), microcredit) can also improve psychosocial outcomes or be combined with other PSS programming. These interventions can help support survivors who are experiencing wider psychosocial stressors due to poverty, support them to increase their assets and, for group-based interventions such as VSLAs, deepen their social support networks. Programmes that have been designed to target adolescent girls have been found to promote re-integration into school, as well as skills development to generate income and provide social support (see for example, [Girl Shine](#)).

More specialised support efforts – such as group or individual counselling to improve psychosocial functioning after an incident of violence – are also implemented in humanitarian settings. Many of these approaches are based on western counselling interventions (e.g. Cognitive Behavioural Therapy, Cognitive Processing Therapy)

implemented by social workers. Research studies have demonstrated that these approaches – particularly those that utilise group-based methods - can improve psychosocial functioning of women in conflict-affected contexts.<sup>56,57</sup> Additionally, M&E toolkits have been developed to help define and measure outcomes (see for example, [IRC's Gender-Based Violence Case Management: Outcome Monitoring Toolkit](#)). However, limits to the methodologies of most of the evaluations (e.g. lack of control groups; high loss of client follow-up due to the mobility of the population and other demands on their time that lead them to not participate in follow-up interviews; focus on survivors of sexual violence; lack of follow-up to measure long-term impact) make it difficult to draw many firm conclusions about 'what works' to improve psychological functioning among GBV survivors in humanitarian settings.

## GBV Response during the COVID-19 pandemic

The GBV community has been working to adapt guidance and existing programming models in light of the ongoing crisis. For example, case management and data management in the context of COVID-19 ([Case Management, GBVIMS/GBVIMS+ and the COVID-19 pandemic](#)).

Some service modifications that have been seen during the pandemic include:

- Adaptations to remote service provision (phone hotlines, internet based services)
- In-person service points (with infection control provisions) targeted to women and girls who lack connectivity

See examples of some of these models here: [Not Just Hotlines and Mobile Phones: Gender-based violence service provision during COVID-19](#)

# RESPONSE

## Health

Health programmes to support survivors of GBV often involve building the capacity of individuals or institutions to provide appropriate, confidential and survivor-centred care when survivors present for treatment. This includes training and support for healthcare staff to care for survivors of rape and sexual assault including child survivors. Intimate Partner Violence is less commonly included in these guiding documents and training materials – possibly because sexual violence is explicitly prioritised in the reproductive health priorities for service delivery during humanitarian crisis, as laid out in the **Minimum Initial Service Package** (MISP).

In addition, efforts are made to improve the functioning of the health clinics and the wider health system to support survivors, including establishing/rolling out minimum standards for caring for survivors, providing medication or other necessary medical supplies, such as the United Nations Population Fund’s (UNFPA’s) reproductive health kits. While static health delivery models are the most common, mobile service provision also occurs – particularly in hard-to-reach areas.<sup>58</sup> However, there has been little evaluative activity that documents implementation or assesses the impact of static or mobile sexual and reproductive health (SRH) activities for GBV survivors.<sup>59</sup>

To increase the integration of health services and wider case management/PSS, in some settings GBV case managers or social workers who can provide PSS are placed at health facilities or nurses/midwives work in WGSS.<sup>60</sup> In addition, there have been efforts to introduce screening tools in health facilities to identify women experiencing GBV so they can be linked to services in a more proactive manner.<sup>61</sup> Furthermore, health staff may be involved in building legal cases against perpetrators of GBV by collecting evidence, completing medical certificates, etc. Where these services are available, staff are given training and support on how to collect and document forensic evidence of sexual violence to bolster accountability and effective prosecutions of these crimes (see for example, **Physicians for Human Rights model**).

“The health facilities are located far away and at the same time there are also no vehicles to facilitate transport to the health facilities.”

Woman – Uganda

# RESPONSE

## Health

These efforts to integrate services (including legal and protection services) have led to one-stop models that provide a comprehensive range of services to support survivors including reproductive healthcare, psychosocial counselling, referral and advocacy services to survivors of GBV out of one location (see for example, **The Rainbo Centres in Sierra Leone**).<sup>62</sup> These approaches aim to reduce stigma (as GBV is only one of many services provided at these centres) and the barriers that women experience which prevent them from seeking further support after disclosing an incident of violence. While there have been no specific evaluations of the efficacy of this approach in humanitarian settings, they have been commonly utilised in LMICs throughout the world.<sup>63</sup>

In addition to these services that rely on highly trained health workers (e.g. doctors, nurses, midwives), there are also community-based service models emerging as an alternative approach for supporting survivors in particularly remote or hard-to-reach locations. For example, in one pilot study, community healthcare workers (CHWs) were trained to provide support to survivors of sexual violence, based on the WHO Clinical Management of Rape protocol. After the conclusion of the training, the participants were found to have sufficient knowledge of clinical care and confidentiality.<sup>64</sup> Similarly, Médecins Sans Frontières (MSF) has developed a 'light' model of service provision (focused on psychosocial first aid and emergency contraception) for areas where there is high insecurity and no regular medical care.<sup>65</sup> These approaches are limited, and rigorous research has not proven their effectiveness. However, they are potential avenues for expanding coverage in areas where full health services are not available or are overstretched.

“We have faced some challenges from parents about coming to the centre. [Parents ask:] how will you go alone as a woman? What can you learn at this age? It is all of no use. [Or:] you are a widow. What will people say about you when they see you going alone?”

**Woman – Voices of Syria**

# RESPONSE

## Protection

Support for immediate protection needs are typically provided by local police, United Nations (UN) police, or other members of the security sector. Interventions targeting the police usually seek to build capacity to provide confidential, supportive and survivor-centred care. Often these are delivered by supporting the establishment of Women and/or Family Desk/Units by national police forces. These units/desks act as focal persons who have typically received special training on how to engage with a survivor and are called in to support survivors when they disclose an incident of violence. While these approaches can be helpful, structural issues (e.g. staff turnover or transfer, corruption, wider impunity and/or patriarchal norms within police forces, limited supplies and equipment to use during investigations) often prevent these efforts from reaching their full potential and there is limited evidence on their effectiveness in humanitarian settings.

Within the UN structure, Women Protection Advisors are now included in many peacekeeping missions, and codes of conduct on GBV and guidelines on compliance with UN policies for addressing GBV have been developed. Peacekeepers are trained on conflict-related sexual violence as part of the standardised pre-deployment training package, and standardised training materials have also been developed for UN Police. However, for both of these groups, gender and sexual violence is only one component of a vast training package, and observers have noted that the time given to these subjects is short – suggesting a limited potential impact for these efforts.<sup>66</sup> A 2010 study on the impact of United Nations Security Council Resolution 1325 similarly concluded that efforts to address GBV through the women, peace and security agenda (including security sector reform, peacekeeping, etc.) had limited impact in reducing GBV in conflict settings.<sup>67</sup> While this study is now 10 years old, more recent research continues to suggest that GBV is not prioritised within this work and that there is a vast gap between international policies and implementation on the ground, and measurable impact in improving the lives of women and girls.<sup>68</sup>

As noted by commentators, ‘gender training does not occur in a vacuum: the weakness of the UN in seriously addressing gender inequality in leadership positions, as well as allegations of sexual exploitation and abuse by peacekeepers, has introduced inconsistency. It has also undermined the norms that the UN sought to inculcate in peacekeepers about their role in promoting gender equality and in combating sexual exploitation and abuse and sexual and gender-based violence’.<sup>69</sup>

Beyond national or UN police and security forces, other important mechanisms for the protection of women and girls experiencing GBV include shelter or safe house systems run by the UN, NGOs, CBOs and/or the government. There are also limited examples of community-based networks of individuals and organisations or networks of community hosts providing shelters in camp and urban settings.<sup>70</sup> Despite the importance of these resources, in humanitarian settings often there are few shelters and those that exist may be stigmatising for the women and girls who seek to access services.

“Since the case has reached the police, everyone will know about it...She will be ashamed and feel bad because everyone will laugh at her and talk about her incident. She will be distressed, depressed and even become mad.”

**Woman – South Sudan**

# RESPONSE

## Legal / Justice

Legal support for survivors is often one of the weakest components of a referral pathway, as it is dependent on national (or international) legal systems that the humanitarian community has a limited ability to influence. Typical interventions in this area include strengthening the capacity of court actors (including judges) to promote survivor-centred approaches, ensure confidentiality, etc. Similar efforts are made when supporting traditional courts, which often provide legal adjudication for some GBV cases, such as those involving agreements between the survivor’s and perpetrator’s families. As with formal court systems, these informal structures can be patriarchal and unsupportive of women (for example, research has often documented incidents of women being blamed for experiencing rape, or being married to their perpetrators).<sup>71</sup>

To reduce barriers and bolster legal services in humanitarian settings, programmes also support legal aid and counselling centres, and provide support/accompaniment services to survivors dealing with the police and the courts. These programmes can include staff training and capacity building for lawyers, law students and psychologists/psychosocial assistants on issues such as the causes and effects of violence, and the principal rules and standards related to human rights. In contexts where the static court system does not have full coverage or is overwhelmed, mobile courts are often used to bring rule of law to the communities themselves.

In addition, there may be support for government processes to increase the speed of interventions and efforts to amend laws or other legal frameworks to recognize GBV (including forms of violence not always

noted in legislation, such as marital rape) and reduce barriers to prosecution. Some examples include: the 2012 Sierra Leone Sexual Offences Law, which mandates ‘stiff minimum sentences for perpetrators of sexual violence’; in 2006 the Democratic Republic of the Congo introduced legislation that defined rape and criminalised it; and in Liberia, which amended its existing ‘rape law’ in 2005 to increase the sentencing for convicted rapists and expand the definition of rape.<sup>72</sup> While most of these legal victories occurred after the conclusion of conflict (or in contexts where protracted conflicts did not affect the national capital), much of the groundwork and advocacy for these changes began during the conflict and the immediate post-conflict period. As noted by researchers, conflict and the transition to a post-conflict period can be an opening for new legislation and protection for women and girls to be introduced.<sup>73</sup>

“Because of impunity, women have been traumatized[.] [T]hey don’t want to speak up about what happen to them or to seek help.”

Stakeholder IRC  
Research Myanmar

# KEY RESPONSE SUPPORT DOCUMENTS

## RESPONSE PROGRAMMING

[Interagency Gender-Based Violence Case Management Guidelines](#)

[Caring for Survivors of Sexual Violence in Emergencies: Training Guide](#)

[Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings](#)

[UN Essential Services Package for Women and Girls Subject to Violence](#)

[UNICEF Gender-Based Violence in Emergencies Programme Resource Pack](#)

[Women and Girls Safe Spaces: A Toolkit for Advancing Women's and Girls' Empowerment in Humanitarian Settings](#)

[GBV Emergency Response Program Model](#)

[Inter-Agency Minimum Standards For Gender-Based Violence in Emergencies Programming](#)

## MHPSS

[IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#)

[IRC's Women Rise: A Gender-based Violence PSS Toolkit \(forthcoming\)](#)

[Gender Based Violence Training Manual](#)

## HEALTH

[Guidelines for Health Staff Caring For Gender-based Violence Survivors - Including Protocol For Clinical Management of Rape](#)

[Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings](#)

[Clinical management of rape and intimate partner violence survivors](#)

[Clinical Care for Sexual Assault Survivors](#)

[Inter-agency Field Manual on Reproductive Health in Humanitarian Settings](#)

[Minimum Initial Service Package \(MISP\)](#)

## PROTECTION/LEGAL

[A Guide to Sexual and Gender-Based Violence Legal Protection in Acute Emergencies](#)



PREVENTION

## PREVENTION

### Causes and drivers of GBV – the perspectives of women and girls

“There is fighting between husbands and wives because of money. A wife needs money for food and a husband has nothing.... This money issue will cause arguments and fighting.”

**Woman - South Sudan**

“Physical violence happens when we ask for money for buying soap, our men get angry and beat us.” **Woman - Uganda**

“There are some restrictions on movement because of the customs and traditions of society.” **Adolescent Girl – Voices of Syria**

“‘I beat her’, they are saying. ‘I paid for you too much money to your father... Then I have bought you.’ And then the girl is violated and beaten.” **Woman – Unite for a Better Life Research Ethiopia**

“Girls who live with their parents are protected by them... married women are protected by their husbands... mostly girls who aren’t married and who don’t have parents live in danger.”

**Adolescent girl – Lebanon**

GBV prevention interventions seek to avert acts of violence before they occur. Traditionally, prevention programmes have not been prioritised in humanitarian settings, where the focus has been on shorter-term activities that mitigate the risk of a woman or girl experiencing GBV and response efforts to support survivors after an incident of violence occurs. Effective prevention interventions in non-conflict settings typically take a long-term approach to behaviour change and work on multiple levels of the socio-ecological framework (e.g. societal, community, and individual) to change social norms around violence and shift power dynamics between women and men. High-quality impact evaluations have demonstrated that it is possible to reduce rates of GBV in relatively limited timeframes (around two to three years) in LMICs.<sup>74</sup> However, because these programmes tend to focus on long-term behaviour change, they are often not well suited to acute emergencies.

**Despite this traditional de-prioritisation, in recent years there has been increased attention on developing prevention models appropriate for humanitarian settings.**

As most humanitarian settings last for years, if not decades, it has become increasingly recognised that prevention programming is possible – particularly in refugee or displacement settings where the affected population is relatively settled. In these protracted settings, humanitarian agencies often implement aspects of popular prevention programmes such as: **SASA!**, **Stepping Stones**, **Unite for a Better Life**, **Engaging Men through Accountable Practice (EMAP)**, and other social norms change interventions. However, there has been limited examination of the fidelity of these approaches and it is not clear if organisations are fully implementing these models in humanitarian settings or if the models have the same impact as seen in non-conflict settings.

# PREVENTION

While prevention programmes in humanitarian settings have traditionally focused on increasing awareness of GBV, there is increasing understanding that these approaches have limited impact and will not change attitudes and behaviours. Most documented prevention programmes currently being implemented work through community leaders, peers and other change agents facilitating community discussions around GBV. Media (radio, films, podcasts, drama/theatre skits) are also often utilised to increase awareness and facilitate changes in attitudes. These programmes also often employ participatory approaches to build skills and empower the affected populations to tell their own stories or develop new messages.

One important principle of prevention programming learned from successes in LMICs is that prevention programming needs to engage beyond women and girls. In humanitarian settings, this is often operationalised, either independently or as a component of a wider social norms change intervention, as 'engaging men' approaches. These strategies include conflict resolution programmes to develop men's skills to resolve community and relational conflict

without violence; most commonly, men known to have engaged in IPV participate in discussion groups to identify and practice non-violent responses to triggers that would normally result in violence.<sup>75</sup>

**While still limited, there is increasing empirical evidence being generated about 'what works' to prevent GBV in humanitarian settings.** For example, UNICEF's **Communities Care** programme (piloted in conflict-affected communities in Somalia and South Sudan) sought to strengthen positive social norms that protect women and girls from violence through community discussion groups and collective community action and strengthen formal and informal support structures by changing social norms of providers and institutions. An impact evaluation conducted by Johns Hopkins University found that there were sustained positive impacts on personal beliefs and changes to social norms around GBV among those exposed to the programme.<sup>76</sup> In addition, programmes that seek to engage men to change beliefs and attitudes around GBV have been found to contribute to decreases in IPV in conflict-affected Côte d'Ivoire.<sup>77</sup>

“One of the causes of problems is lack of money. Women are raped, kidnapped, and parents marry their daughters to get rid of them and throw the burden on someone else.”

**Woman – Voices of Syria**

# PREVENTION

Beyond working to change social norms, prevention programmes use other mechanisms to contribute to changing power dynamics and reducing GBV. One common mechanism is women and/or girl’s empowerment programmes. This programming often includes livelihoods and/or skills training aspects that seek to increase a woman’s control over assets and allow her to generate her own income. While these programmes have had some impact, there is growing recognition that livelihoods/economic empowerment programmes alone are not able to reduce GBV and that as women take on more ‘masculine’ roles around providing for the family, they might also experience increased violence.<sup>78</sup> In response to this, new models are being created that incorporate economic empowerment programming or livelihoods programmes with gender transformative mechanisms – for example gender dialogue groups combined with VSLAs have been seen to reduce violence in conflict-affected communities.<sup>79</sup> However, it should be noted that most of the empirical evidence on these programmes comes from post-conflict settings, and best practices in acute emergencies remain less clear.

Empowerment programmes also often target specific sub-groups within the affected populations – adolescent girls, for example. Programming models such as the International Rescue Committee (IRC)’s Girl Shine model, and its predecessor approaches: COMPASS and Girl Empower, work to support girls through mentorship, skills development, parental engagement and safe spaces. Impact evaluations of these models have found improvements in the lives of girls (e.g. more friends, life-skills, self-efficacy mentors) and the Girl Empower programme reduced rates of child marriage and risky sexual behaviours.<sup>80</sup> School-based programmes also work to change norms and reduce violent behaviours/experiences among school-going boys and girls. For example, the Help the Afghan Children (HTAC) peace education programme in Afghanistan facilitated reductions in school-aged boys and girls reporting peer violence (perpetration and victimisation). Participants also witnessed less non-partner family violence against their mothers, experienced reduced corporal punishment in both school and home settings, and had improved gender-equitable attitudes after the intervention.<sup>81</sup> While these programmes targeting adolescents

and children show promise, most of the evidence demonstrating their effectiveness has been generated in post-conflict or protracted crisis, and it remains to be seen if these gains would be similar in active humanitarian crises. Furthermore, no long-term follow-up has been done to see if these youth interventions have lasting impacts on reductions in violence (perpetration and victimisation) into adulthood.

“Women and girls have no voice; their uncles and fathers manage the dowry. 14–15 year old girls can be married off to 60 year old men. The girl has no choice and the mother has no right to refuse either.”

**Woman – South Sudan**

The image features a dark blue background with several stylized, colorful lines in orange, teal, and purple. These lines are arranged in a way that they appear to be connected to the central text, with some lines extending to the edges of the frame. The lines have rounded corners and some segments are dotted. The overall aesthetic is modern and clean.

# PRIORITY GAPS

# PRIORITY GAPS

Gap areas were identified through the literature review and global consultation process and were then organised into a framework that differentiates between GBV risk mitigation, response, and prevention strategies.

We began by examining gaps relevant to GBV risk mitigation and response programming, as the situational analysis identified that, compared to prevention, these areas were more commonly prioritised within humanitarian response. Within these groupings, existing approaches were reviewed. We took account of the strength of intervention design, reach, and demonstrated effectiveness. The research team then identified 'gap' areas where new programming or policy approaches are needed, where existing interventions require strengthening, or where evidence is needed to assess the effectiveness of the approach. Further gaps were identified or refined through virtual consultations with humanitarian aid workers from the around the globe.

The priorities listed on the following pages are the areas of greatest need, as seen from the perspectives of humanitarian aid workers. The priority gap areas identified here are relevant to many different actors within the humanitarian community and serve to highlight key areas of need/action from donors, help inform practitioners in programmatic decision-making/design/prioritisation, and provide calls to action for researchers to explore evidence gaps.

While most of the identified gaps could fit in many of these categories (e.g. creating a new approach or improving an existing intervention are often both relevant actions in a situation where existing programmes are not working; more evaluations are needed throughout the sector), we sought to classify each gap based on area of greatest need. Input was received and synthesised from members of humanitarian community and Steering Committee members to help develop the final ordering of the priority lists below. The final lists are ordered to reflect the most important to least important priorities, based on the results of the situational analysis, the consultations with the humanitarian community and input from the project's Steering Committee.

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# PRIORITY GAPS

These identified gaps include both systemic and operational issues that impact the delivery of effective GBV programming.

Systemic barriers – such as lack of funding, overall accountability systems, or commitment/leadership on an issue - are often based on the wider power inequities inherent in the humanitarian aid system and affect the delivery of humanitarian aid in general, as well as preventing the prioritisation of and support for effective GBV programming specifically. Operational gaps are focused on more discrete programming or policy barriers that affect the delivery of effective interventions. For example, lack of capacity or training packages, ineffective programming models, or lack of evidence demonstrating that existing programmes are effective.

In order to draw attention to the differences between those areas, we note whether each gap area is 'systemic' or 'operational' in nature. While efforts are needed to address both systemic and operational gaps, there may be differences in the stakeholders that need to be engaged, or the potential approaches that could be utilised to address these issues, depending on the nature of the gap. In addition, we have identified key themes, or overarching issues, affecting GBV programming at large, that run throughout this analysis, including: limited funding, weak capacity, lack of prioritisation and commitment for organisations, donors and other sectors, lack of accountability mechanisms, limited community participation, limited programming/interventions, and lack of evidence of the effectiveness of approaches.

By working to address these gaps, the humanitarian community will begin to break down some of the most important barriers that prevent effective GBV risk mitigation, response and prevention programming.

# Women and girls insufficiently engaged when identifying risks, developing mitigation plans, and monitoring implementation

## GAP TYPE



Operational

## KEY THEMES



Limited community participation



Lack of accountability

Participation is often a nebulous concept to humanitarian practitioners, operationalised as gathering data from the affected population to assess needs, rather than the co-creation and delivery of programming or recognition of participation as a universal right. The nature of acute crises can impact the ability of humanitarian agencies to fully integrate participatory principles throughout humanitarian action. In addition, humanitarian aid workers may not know how best to engage with women and girls around GBV risk mitigation in safe, ethical and participatory ways.

However, participation is an essential component of risk identification and mitigation activities. While some risks can be objective and easy for an outsider to identify (e.g. lack of lighting on path), others may not be obvious to someone from outside the affected community. In addition, the perception of risk can also greatly impact the lives of women and girls in these settings. Research has documented that the perceived

threat of sexual violence can impact men's attempts to control the lives of women, as well as potentially increase the rates of CEFM.<sup>82</sup> Furthermore, areas and activities where women and girls perceive risk typically correspond to where their risks are actually increased. Incorporating their input and perspectives throughout the risk identification and mitigation processes is therefore essential. As described by an informant, "Centring survivors' voices [is important] to ensure risk mitigation is guided by voices of women and girls".

Current risk mitigation approaches often include roles for women and girls (e.g. focus groups, safety walks) during risk identification (see for example; ACTED's **Standard Operation Procedures GBV Safety Audit** and UNFPA/International Medical Corps' (IMC's) **GBV Assessment & Situation Analysis Tools**). However, this is where engagement often stops, as women and girls are rarely included in the process of developing risk mitigation plans and monitoring their implementation.

Existing risk mitigation activities (e.g. the identification of risks) do not fully involve women and girls in the development of mitigation activities and monitoring their implementation. By better engaging this population, mitigation efforts would better promote a 'do no harm' approach and ensure that the work of the humanitarian community is accountable to the affected populations. While there are examples of good practice in engaging women and girls throughout both the risk identification and mitigation process (see for example, **Oxfam's work in Lebanon**), these remain limited and there is a need to build upon these efforts to create new opportunities for the engagement of women and girls throughout the programming cycle.

## Lack of community ownership of risk mitigation activities

### GAP TYPE



Operational



Systemic

### KEY THEMES



Limited community participation



Lack of accountability

GBV risk mitigation activities are targeted interventions that reduce the risk that a woman or girl experiences violence. These activities are often designed and implemented by humanitarian aid workers, rather than by the affected communities (see for example, the [IASC Guidelines](#), which primarily focuses on the aid sector). While some risk mitigation activities fall squarely within the remit of these practitioners (e.g. installing locks on latrine doors, ensuring there is lighting in highly trafficked areas), others lie within the community and mitigation activities should be led by the communities themselves.

Centring women and girls is important in this process. However, on their own, they often lack the power to mitigate the risks they experience. They need the support of, and to work with, community leaders to together create safer environments for women and girls to live in. More efforts are needed to create opportunities for community ownership in risk mitigation activities.

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## Lack of evidence to understand the impact of risk mitigation activities

### GAP TYPE



Operational

### KEY THEMES



Lack of evidence

While many organisations engage in some form of risk mitigation activities, the existing evidence base examining whether these activities are actually reducing the risk of violence is very weak (e.g. studies that only utilise pre- and post-data and no comparison groups, have small sample sizes, are limited in scope). Data to measure safety and to understand the impact of risk mitigation activities is often not collected. In addition, while limited evaluations have documented reductions in reported cases of sexual violence during periods of firewood distributions and in negative activities occurring after the installation of solar lights, the quality of the research methods utilised to document impact is generally poor. In addition, more focus is needed to improve both the collection of routine M&E data around the effect of mitigation activities and to better analyse existing data collected through routine M&E systems.

This includes developing and disseminating further case studies showing successful practice. New initiatives, for example UNICEF's ongoing efforts to better understand what safety means and how it should be measured in these contexts, aim to narrow this gap.<sup>83</sup> However, this is only a first step. Further learning and research is clearly needed.

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## Lack of commitment across all sectors to implement and prioritise GBV mitigation activities

### GAP TYPE



Systemic

### KEY THEMES



Lack of prioritisation and commitment



Lack of accountability

As described by a respondent, one of the systemic challenges facing the humanitarian community is the “entrenched gender biases and harmful norms in the development and humanitarian community itself”.

One way these gender biases manifest themselves is through a de-prioritisation of GBV activities by other sectors. While a lack of commitment is not the only barrier to mainstreaming GBV risk mitigation activities, it is one of the most crucial. Commonly described by survey respondents as a ‘lack of interest’ or a ‘lack of commitment from senior management to prioritise risk mitigation’, **there remains a perception – despite considerable efforts from the GBV sub-sector – that GBV risk mitigation activities are somehow separate from the core responsibilities of other sectors.**

While identifying and mitigating GBV risks is often described as ‘everyone’s job’, this mainstreaming can have the effect of making it, in reality, no one’s job. As noted in the **Call to Action Roadmap**, there is a lack of prioritisation of GBV programmes at both the global and field level, which amount to systemic barriers that affect GBV programming of all types.<sup>84</sup>

The GBV AoR has recognised this challenge and made considerable efforts to mainstream and embed GBV risk mitigation efforts in the work of other sectors. Documents such as the **IASC Guidelines** and the sector-specific integration of GBV risk mitigation guidance into other sectors’ own materials (see for example; the Shelter Cluster’s **GBV Constant Companion**, the WASH Cluster’s **Minimum Commitments to Safety and Dignity**, Camp Coordination and Camp Management’s **(CCCM’s) Camp Management Toolkit**) are a step forward. On their own, however, they are not enough to fully bridge this gap, as

there is little evidence that most sectors are prioritising mitigating the risks of GBV. More effort is needed to change behaviours and norms stemming from gender biases within all sectors and to support these groups to prioritise GBV risk mitigation activities.

“It still seems like it’s on the GBV sector to improve risk mitigation, when it’s supposed to be on the other sectors.”

Survey Respondent

# Lack of accountability to ensure GBV mitigation activities are prioritised

## GAP TYPE



Systemic

## KEY THEMES



Lack of prioritisation and commitment



Lack of accountability



Lack of evidence

There is a lack of accountability in addressing the safety issues identified during risk mitigation assessment activities (e.g. safety audits, assessments, mapping exercises). For example, while sample tools and safety audit reports are published, there are rarely follow-up reports documenting what actions were taken to reduce risks and improve safety. As described by a respondent, "Often, when we share recommendations from safety audit reports, other partners are reluctant to receive this feedback and no one is holding them accountable on the implementation of those recommendations". Even at the individual organisation level, there is often "zero accountability for staff to identify risks and mitigate those risks" (survey respondent).

The lack of oversight and accountability mechanisms (e.g. tying risk mitigation activities to job performance, including tracking of activities such as safety audits as part of the management activities of organisations' senior leadership teams) has significantly contributed to the overall low accountability at all levels of the humanitarian system to mitigate GBV risks.

This gap is also reflected in limited donor engagement in ensuring accountability. As described by one respondent, "Donors need to start requiring it [risk mitigation] within their reporting guidelines as well as including it as a budget line". While some donors require potential grantees to conduct a gender analysis or explain how their

programming may affect risks of violence and what their mitigation plans are, this is not consistent. In addition, after a proposal has been funded there is often no follow-up (e.g. submitting the results of safety audits, reporting against the issues identified within those documents) from donors to monitor whether efforts have been made to identify and mitigate risks. More attention is needed from donors to develop new mechanisms to support operational agencies to prioritise risk mitigation activities.

## Lack of accountability to ensure GBV mitigation activities are prioritised

### Continued...

There have been examples of good practice that are working to systematically build commitment to, and accountability for, the implementation of GBV risk mitigation programming. For example, the RTAP programme is working on a system-wide approach to ensure all actors prioritise and coordinate their GBV actions. Emerging evidence from piloting processes shows that practical tools such as the RTAP-developed **GBV Accountability Framework** have improved stakeholders' ability to coordinate, consider GBV in strategic planning and prioritise GBV activities.<sup>85,86</sup>

Furthermore, consistent, sustained support and engagement of GBV actors, and co-funding of GBV and other sector programming, has been seen to lead to improvements in integration of GBV activities. There are some examples that show promise, such as in South Sudan where sustained engagement from UNICEF with the WASH sector has led to the inclusion of a sectoral objective and indicators on mitigating WASH-related GBV in the 2020 HRP. But much more still needs to be done, both at high levels (ensuring commitments of leadership; incorporating GBV more fully into sector plans within HRPs; engagement from donors) as well as at organisational and community levels to build accountability for risk mitigation activities. More rigorous evaluations of promising initiatives such as RTAP are also needed to build the evidence as to what works.

“zero accountability for staff to identify risks and mitigate those risks”

Survey Respondent

# Lack of comprehensive, systematic and flexible funding to implement risk mitigation activities

## GAP TYPE



Systemic

## KEY THEMES



Lack of prioritisation and commitment



Limited funding

Appropriate funding is an essential component of any successful programme. However, for many organisations, funds for GBV risk mitigation activities end at the risk identification stage (e.g. implementing safety audits) and do not include discretionary funding that will allow the organisation to make changes to reduce the risks identified. Other cross-cutting areas – such as M&E – have begun to be prioritised in humanitarian settings, in part because donor guidance often mandates a certain percentage of any budget is dedicated to M&E activities. It is possible to learn from these approaches, however the lack of systematic, consistent and flexible funding continues to limit humanitarian organisations’ ability to mitigate identified risks.

For many organisations, funds for GBV risk mitigation activities end at the risk identification stage.

# Lack of knowledge and support to operationalise/implement risk mitigation activities, especially for non-GBV specialists

## GAP TYPE



Operational

## KEY THEMES



Weak capacity

Even for humanitarian practitioners who are committed to implementing GBV risk mitigation efforts, there remains a capacity gap in understanding and implementing quality and effective activities. One of the strengths of the current GBV risk mitigation approach is the effort to mainstream mitigation activities and make reducing risks a core aspect of 'implementing good programming', rather than an extra task. However, the effect of this approach is that many practitioners from other sectors with no gender or GBV background (and often with their own patriarchal views on gender, violence, etc.) are charged with identifying and mitigating GBV risks. In many cases, they lack the ability to effectively identify GBV risks and implement risk mitigation activities.

There have been considerable efforts to create simple-to-use guidelines and tools to support risk identification activities, and the [IASC Guidelines](#) clearly lay out how GBV risks can be mitigated within different sectors. Risk analysis is normally included as

part of the HPC, and multi-sector and sector-specific risk assessments are taking place regularly. However, appropriate mitigation activities are not always implemented in response to these identified gaps, as humanitarian actors may not know how to respond appropriately to identified risks. As described by a respondent, **"Risks are normally clearly identified. More should be done to invest in ensuring matching mitigation strategies are well planned for and implemented, based on learning from past experiences."** More support is needed to ensure these stakeholders know how to both appropriately identify and mitigate these risks.

Some initiatives that have demonstrated promise include training/support packages that have helped non-GBV specialists increase knowledge and build the skills required to turn this knowledge into practice.<sup>87</sup> Examples include IMC's [Managing Gender-Based Violence in Emergencies Global Learning Programme](#) and the University College Dublin's [International School](#)

### **on Addressing GBV in Emergencies.**

Similarly (though not specifically focused on humanitarian settings), online programmes such as [GenderPro](#) that take practitioners through basic concepts and then support implementation through practical on-the-job projects also hold promise to build capacity at scale. Smartphone and web-based training programmes – such as IRC's [Remote-Offered Skill Building App \(the Rosa platform\)](#) - also seek to build skills and share learning.

However, these training programmes are typically not targeted at non-GBV specialists and do not necessarily focus on risk mitigation. Existing mechanisms which offer support, such as the [GBV AoR Helpdesk](#), may not be known to practitioners in other sectors, as there are few formal partnerships between the GBV AoR and other sectors. Increased investment and support targeting non-GBV specialists specifically is needed to build capacity of these staff so they are able to effectively mitigate risks in their own programming.

## Lack of programming models to reduce risks where there are access limitations or where women cannot move freely

### GAP TYPE



Operational

### KEY THEMES



Limited programming / interventions

Risk mitigation programmes emerged from traditional humanitarian response settings (e.g. refugee or internally displaced person (IDP) camps) and, as such, are typically designed for locations that are accessible (e.g. where safety audits can be conducted, where women and girls can be engaged to identify risky areas), where it is much easier to identify risks and implement mitigation strategies. There has been less effort to understand how this programming can be delivered in contexts where women and girls face limitations on their movement outside the home without male accompaniment, or in contexts such as public health emergencies that require isolation and limit movement. As described by one respondent, “Risk mitigation in public health emergencies remains non-existent, and that is deeply problematic”.

Furthermore, in humanitarian settings, risks for women and girls often also increase within the home, where there are increasing risks of experiencing IPV, CEFM, etc. However, **risk mitigation projects are often only focused on prioritising risk reduction within the wider community and rarely consider household-level risks, which may increase in particular in areas where women have limited freedom of movement and in public health emergencies.** New approaches are needed to determine how best to connect with women and girls in these settings and identify risks they may be experiencing.

“Risk mitigation in public health emergencies remains non-existent, and that is deeply problematic.”

Survey Respondent

## Lack of sustained support for those providing essential PSS and GBV case management services

### GAP TYPE



Operational

### KEY THEMES



Weak capacity

In humanitarian settings, case managers may have limited training, and even those staff with advanced qualifications, such as a social work degree, may not have had academic training in, or on-the-job experience of, working with survivors of GBV. This can impact the quality of case management support. As described by a respondent, “The quality of GBV case management services is sometimes very limited in some contexts, with staff in field locations sometimes not having received adequate training or support to deliver case management, and working on very short funding cycles that do not allow long-term investment in professional skills”. Given the need to hire women from the same/similar

cultures as the affected population and with relevant language skills to support survivors, it is likely that a considerable amount of on-the-job support and training will be needed for new hires. Global toolkits such as the [Interagency Gender-Based Violence Case Management Guidelines](#) have been developed to guide global practice. However, improved initiatives (e.g. training, supportive supervision, feedback mechanisms) are still needed to support these frontline workers in delivering effective care for survivors.

In addition, a core aspect of the job of case managers is to provide PSS to survivors (well-designed and implemented PSS programming can improve survivors’ wellbeing). Nevertheless, **case managers often need to balance the work of providing PSS with a myriad of other responsibilities** (e.g. the general functioning of WGSS, GBV prevention activities, managing staff or volunteers, conducting trainings, engaging with community leaders, preparing reports).

“The quality of GBV case management services is sometimes very limited in some contexts, with staff in field locations sometimes not having received adequate training or support to deliver case management, and working on very short funding cycles that do not allow long-term investment in professional skills.”

Survey Respondent

## Lack of sustained support for those providing essential PSS and GBV case management services

### Continued...

This can result in weak psychosocial programming, or in the prioritisation of other activities, which may limit how effective psychosocial activities are in improving survivor wellbeing. As described by a survey respondent, “Women and girls safe spaces activities are more likely to focus on awareness-raising than on the types of social, peer and psychosocial supports that are more likely to be helpful to women and girls”. And, by another, “Programmers are often dependent on guidance from IASC and others (without much of their own experience) but this guidance is not very detailed. For example, psychosocial support often ends up looking like life skills, safety planning (a basic initial service) is rarely offered and often misunderstood”.

More technical guidance and support is needed to ensure that response staff can deliver both case management and PSS effectively. While new toolkits are being developed to support the delivery of psychosocial programmes in emergency settings ([IRC’s Women Rise: A Gender-based Violence PSS Toolkit](#), for example), the availability of a toolkit alone will not directly lead to improved programming without sustained training and support for those implementing these strategies. Furthermore, guidance and tools are being created by groups such as the IASC’s Mental Health and Psychosocial Reference Group, but often these efforts are not linked to the GBV AoR or they fail to take into account the specific needs of GBV survivors. The limited coordination between GBV and MHPSS sectors to tailor support materials and trainings specific to the needs of GBV survivors impacts the effectiveness of the case management services the humanitarian sector is able to provide.

“Women and girls safe spaces activities are more likely to focus on awareness-raising than on the types of social, peer and psychosocial supports that are more likely to be helpful to women and girls.”

**Survey Respondent**

# The health sector needs better support to provide immediate CMR services and support for survivors of IPV

## GAP TYPE



Operational



Systemic

## KEY THEMES



Weak capacity



Limited programming / interventions



Lack of evidence

While guidance and procedures are available to support the health sector so that facility staff can provide care to survivors of sexual violence and IPV, there is often a gap between these procedures and implementation. General weakness in the health sectors (e.g. lack of sufficiently trained healthcare workers, lack of supplies) affects the provision of services for survivors of GBV. Health workers receive training on a plethora of topics over the course of their jobs, and simply attending clinical management of rape (CMR) training may not necessarily translate to effective and supportive care for survivors. In addition, the health sector overall and/or individual service providers – who may hold gender inequitable attitudes and blame women for the violence they experience – may not prioritise support for survivors. As described by survey respondents, “Health service delivery for sexual violence and IPV is piecemeal and not prioritised by health actors or donors,” and “GBV response (CMR, and medical care for physical violence including IPV) prioritisation among health actors (as part of the SRH MISP [Sexual and

Reproductive Health Minimum Initial Services Package]) need to be advocated for and promoted as it’s still low”.

Further efforts are needed to ensure that available trainings and support packages translate into improved service delivery. This need extends not only to technical health providers, but also facilities staff such as guards, receptionists, etc., who act as gatekeepers of facilities access and can stop or deter survivors from seeking support before they even get to a provider.

In addition, at the facility level, there is potential for healthcare centres to act as key entry points for further support – such as case management and PSS. However, women and girls often may not feel comfortable disclosing the violence they have experienced - especially for survivors who experience IPV. This was exemplified by health actors who, when discussing the results of a GBV survey in refugee settlements in Northern Uganda, were surprised by the high number of survivors who reported accessing health

services after an incident of violence. Comparatively, the health centres themselves recorded much fewer cases when compared to what women were reporting.<sup>88</sup> This represents a lost opportunity, as women and girls appear to be interacting with health services, but are not being linked to other GBV services (“Health services can play a key role in terms of entry points to identify GBV survivors, but this is often not done as health actors/staffs are not trained to identify GBV survivors and offer support/refer appropriately” – survey respondent).

While there is debate on the ethics of screening for GBV survivors in health facilities in humanitarian settings, some research has found that these approaches are feasible and may be acceptable to women (though more evidence is needed).<sup>89</sup> **More consideration needs to be given to possible approaches to strengthen health support for survivors and to break down barriers to reporting violence within these settings.**

# Insufficient integration of financial support/livelihoods components into support programming for survivors

### GAP TYPE



Operational



Systemic

### KEY THEMES



Weak capacity



Limited programming / interventions

While women and girls in humanitarian settings consistently face the challenges of poverty, GBV survivors are often particularly impacted. As well as dealing with the trauma of their violent experience, they also must contend with the daily stress of poverty and the inability to provide for their families.

In primary research, women and girls have reported that the stress of poverty and of providing for their families compounded their stress about the violence they experienced.<sup>90</sup> In humanitarian contexts, where much of the population is dealing with these daily stresses, it can be difficult to address psychological issues (e.g. depression, post-traumatic stress disorder (PTSD)) without also addressing these practical concerns. However, when cash transfer or livelihood

programmes are integrated with GBV services the quality may be mixed or may not achieve the expected outcomes (“Very often GBV actors establish livelihood programs without the appropriate expertise to do so, resulting in possibly some MHPSS positive outcomes, but definitely not achieving livelihood outcomes”- survey respondent). More technical capacity and holistic approaches are needed to deliver quality programmes, and more efforts are needed to integrate GBV and livelihoods activities overall.

“Very often GBV actors establish livelihood programs without the appropriate expertise to do so, resulting in possibly some MHPSS positive outcomes, but definitely not achieving livelihood outcomes.”

Survey Respondent

## Safe access to health services for adolescent survivors of GBV

### GAP TYPE



Operational

### KEY THEMES



Weak capacity



Limited programming / interventions

Health services in humanitarian settings remain, by and large, not adolescent-friendly.<sup>91</sup> This affects both the provision of general healthcare (including reproductive health) and the care provided to survivors of GBV.

For many adolescent girls in these settings, having experienced an incident of sexual violence can have lasting impacts throughout their lives. However, girls may be intimidated or not feel safe disclosing violence to healthcare providers – who may hold conservative or patriarchal views and consider the rape as the girl's fault. Concerns about lack of confidentiality and the stigma associated with an experience of sexual violence (for many girls either leading to a lack of marriageability or even forced marriage to the perpetrator of the rape) may also prevent girls from seeking services. Furthermore, healthcare providers may not be trained to support girls experiencing IPV either as dating violence or in cases of early marriage.

There is considerable guidance available on how to implement adolescent-friendly SRH services (see for example, UNFPA's **Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings**). However, GBV is typically only conceptualised as sexual violence in these documents, and support for survivors is not often prioritised in these approaches. Existing adolescent-friendly SRH approaches lack fully-integrated support for GBV survivors and typically do not prioritise support for girls experiencing IPV.

For many adolescent girls in these settings, having experienced an incident of sexual violence can have lasting impacts throughout their lives.

## Lack of coverage of, safe access to, and effective programming within shelters/safe houses for survivors

### GAP TYPE



Operational

### KEY THEMES



Limited programming / interventions

Some women and girls experiencing violence in humanitarian settings want to leave their existing situation – either temporarily or permanently. For these women and girls, shelters and safe houses are a key lifeline of support. In camp settings, limited shelters are usually available through the UN or INGOs, though these facilities often do not have enough capacity to meet the caseload. In addition, these structures may be stigmatising for women and girls seeking support and it may be a difficult/bureaucratic process to access them/be relocated to another camp or location for long-term safety.

In non-camp settings, there are often even fewer options for women, with the few shelters available typically located in the national or provincial/state capitals – inaccessible to most of the population (“Safehouses are not available [in the] nearest areas. Even if they were available

they may not have the capacity to accept survivors as required. The organisations also do not have networks to jointly act on problems and share the scarce human/technical and financial resources” – survey respondent). In addition, the support programming available in these structures is often quite basic and does not provide women and girls with the skills and support they will need to transition and make a new life for themselves outside the shelter system.

A lack of practical exit strategies for survivors (e.g. resettlement in another camp) results in survivors staying in these facilities for extended periods, prolonging instability in their lives and reducing the ability of these systems to absorb more cases. More coverage for shelter/safe house networks, and new approaches to help those utilising these mechanisms to transition out of the shelter, are needed.

“Safehouses are not available [in the] nearest areas. Even if they were available they may not have the capacity to accept survivors as required.”

Survey Respondent

## Limited understanding of and support for informal, community-based services for survivors

### GAP TYPE

 Operational

 Systemic

### KEY THEMES

 Limited programming / interventions

 Lack of evidence

Many women and girls who experience violence do not disclose this experience to a formal service provider.<sup>92</sup> However, they may seek support through informal networks and tell their friends, family and/or other local/religious leaders. As described by a respondent, “More needs to be done to support community level response. We know that in many humanitarian contexts where GBV response is limited, women and girls draw from community level support, including from religious and community leaders, but these actors are often not equipped to address GBV in a gender-sensitive and survivor-centred way”.

Existing programming is often not designed to guide these informal actors and structures to support survivors. Furthermore, the humanitarian community does not fully understand the ways in which communities provide support, and how to structure programmes that do not empower existing patriarchal structures that disadvantage women and girls who seek help through informal channels.<sup>93</sup> Given the continued lack of funding for comprehensive GBV services covering the entire population of need, more needs to be done (through research, piloting, testing) to consider what services look like in remote/hard-to-access locations. More also needs to be done to see how community-based structures can be strengthened and utilised in contexts where they can supplement formal services or where a full multi-sectoral response is not available.

“We know that in many humanitarian contexts where GBV response is limited, women and girls draw from community level support, including from religious and community leaders, but these actors are often not equipped to address GBV in a gender-sensitive and survivor-centred way.”

Survey Respondent

## Lack of knowledge on the long-term impact of PSS for survivors

### GAP TYPE



Operational

### KEY THEMES



Lack of evidence

There is a growing evidence base about what works to support women and girls in the immediate term within psychosocial programming, with rigorous, controlled evaluations providing high-quality data.<sup>94</sup> Furthermore, ongoing M&E efforts provide tools for programme managers to understand and measure PSS outcomes (for example IRC's **Gender-Based Violence Case Management: Outcome Monitoring Toolkit**) so that the impact of these programmes can be seen. However, these efforts have primarily focused on assessing improvement on psychological indicators (e.g. depression, PTSD) throughout and/or at the end of an intervention. While some follow-up studies have begun, overall there is a lack of long-term follow-up to see if these

programmes have a lasting effect on the mental health or wellbeing of women and girls who experience violence. More evidence is needed to understand if existing programming models can effect long-term change.

While some follow-up studies have begun, overall there is a lack of long-term follow-up to see if these programmes have a lasting effect on the mental health or wellbeing of women and girls who experience violence.

# Lack of coverage and survivor-centredness of formal and informal legal and justice services, especially in remote locations

## GAP TYPE



Operational



Systemic

## KEY THEMES



Limited programming / interventions

In the typical referral pathway, the legal/ justice system is often the weakest component of the existing services.

The justice sector often includes formal or informal courts as avenues for punishment of perpetrators and restitution for survivors. Formal legal actors often hold patriarchal attitudes, and available services are not survivor-centred; there can be a lack of privacy and confidentiality, for example. Furthermore, even the existing (often poor quality) systems may only provide services in national or provincial/state capitals, and so women and girls living in rural areas have even less recourse to justice (“There is a lack of holistic services for survivors. Particularly no legal and justice services in most remote locations” – survey respondent).

While some efforts have been made to increase the reach of the justice sector (for example, the provision of mobile courts) these remain limited and inconsistent. In many cultures, informal justice systems fill the gaps in coverage of formal justice.

These rely on local leaders to administer justice, including in cases of GBV. However, these systems are often patriarchal, rely on mediation practices, and are not set up to support survivors. It is important for GBV services to consider how best they can work to shift the norms within these services to make them more survivor-centred.

As described by one respondent, **“Working with traditional justice mechanisms in terms of shifting them so they are more survivor friendly...building capacity and models to be survivor advocates [is important]”**.

New materials – such as Legal Action Worldwide and the Norwegian Church Aid’s **Five Key Guidelines for Providing Remote Legal Aid to GBV Survivors** – are documenting some best practices. However, both the formal and informal systems are lacking when it comes to coverage and services that support the best interests of survivors and lead to justice.

“There is a lack of holistic services for survivors. Particularly no legal and justice services in most remote locations.”

Survey Respondent

# Lack of effective support for police to provide quality, survivor-centred services

## GAP TYPE



Operational



Systemic

## KEY THEMES



Limited programming / interventions



Lack of evidence

Along with the provision of court services, effective and supportive police structures remain a considerable gap (“It is difficult to continue with justice issues for two main reasons[:] it is difficult to keep it as a secret [lack of confidentiality] or due to negligence or deliberate action of polices and judges.” – survey respondent).

While some efforts – the establishment of gender desks/units or similar structures – have been implemented in humanitarian settings, these efforts are often limited and turnover of staff or lack of commitment at higher levels affect these efforts. Police and the wider legal structure are often patriarchal structures in and of themselves. It takes considerable effort to create social norms change within these structures in order to

promote more ethical and survivor-centred care for survivors – though some programmes (see **Communities Care** as an example) are seeking to change these organisational norms. New approaches, as well as further support and evidence of the effectiveness of existing models (e.g. gender desks/units), are required to effect these changes.

“It is difficult to continue with justice issues for two main reasons[:] it is difficult to keep it as a secret [lack of confidentiality] or due to negligence or deliberate action of polices and judges.”

Survey Respondent

# Limited capacity to provide case management services during disease outbreak or where women cannot move freely

## GAP TYPE



Operational

## KEY THEMES



Limited programming / interventions



Lack of evidence

Women do not stop needing GBV response services during public health emergencies or in situations where they are not able to move freely. However, traditional case management services require face-to-face interaction and support. As described by a respondent, “Response in humanitarian settings is challenged in areas where population movements and active conflict prevent adequate and longer-term support to survivors. In these settings, service and governance structures have broken down, making response services such as MHPSS, legal, etc. mostly unavailable and the options for response actors very limited. Additionally in many conflict areas, response actors are operating via remote management and therefore for more specialized response programming such as case management, it is difficult to ensure capacity of and support/mentoring to service deliverers and monitor quality and safety of response interventions”.

**While models utilising phone or internet-based services have been piloted – they are not yet commonly standard options for women in humanitarian crises.** Efforts are needed to bridge the digital divide and connect women and girls to the outside world via technology (“We need more COVID-responsive delivery modalities; getting technology safely into the hands of women and girls to make remote response programming more effective.” - survey respondent). In addition, **in situations where it is not safe or possible for women to use a phone or mobile platform, even more creative ways to reach women and girls are needed.**

Due to necessity, new programming models are being piloted in response to COVID-19 (e.g. code words at pharmacies, desks in central locations where women are still gathering). In addition, there are lessons to be learned from areas such as Syria where

remote GBV programmes have been in place for years (see, for example, IRC’s [Guidelines for Mobile and Remote Gender-Based Violence \(GBV\) Service Delivery](#)).

However, this is an emerging area of practice and further efforts are needed to scale-up these efforts and generate lessons learned for future crises which limit movement.

“We need to meet the needs of women and girls who are invisible – cannot access services, move freely, etc.”

Survey Respondent

## Insufficient support for CBOs/women's rights organisations (WROs) to develop and lead locally-designed prevention programmes

### GAP TYPE



Systemic

### KEY THEMES



Lack of prioritisation and commitment



Limited funding



Lack of evidence

The best available evidence on effective prevention programmes, though primarily generated in non-humanitarian settings, suggests that these programmes should be long-term efforts aimed at shifting inequitable gender social norms to support a re-distribution of power between men and women.<sup>95</sup> These programming models need to be rooted in the existing cultural practices and communities.

Despite this, the humanitarian aid structures are mostly top-down, western-driven programming that treats GBV prevention as short-term activities imposed by outsiders. While problematic throughout the delivery of humanitarian aid, these structures are particularly challenging for GBV prevention work. As described by a respondent,

**“[A]s prevention strategies are seen as long-term or too development-focused, palliative measures are privileged instead of investing resources to build the capacities [of] local actors to work on gender equality, addressing harmful social norms, which ultimately, are the most effective strategies to decrease cases of GBV in a sustainable manner.”**

Despite global promises (including at the World Humanitarian Summit 2016 and **the Grand Bargain**) to increase the localisation of aid, locally-based organisations (including national NGOs and CBOs) are still often marginalised. As one national NGO representative described, “[M]y NGO has not accessed any funding still, but we hope we shall keep on showing the donors and other international NGOs that we have capacity to contribute ideas when [it] comes to GBV issues”.

“[M]y NGO has not accessed any funding still, but we hope we shall keep on showing the donors and other international NGOs that we have capacity to contribute ideas when [it] comes to GBV issues.”

**NGO Representative**

## Insufficient support for CBOs/women's rights organisations (WROs) to develop and lead locally-designed prevention programmes

### Continued...

While the lack of funding directed to CBOs and WROs remains a gap across all GBV programming in humanitarian settings, it particularly affects GBV prevention programmes where localisation is an essential component of programme design and delivery. There have been some efforts to centre women's organisations in humanitarian response, and strengthen local women's movements (see for example, **Building Local, Thinking Global**), however these initiatives are not specific to GBV prevention programming. More efforts are needed to operationalise the localisation agenda and shift the power to locally-based organisations to design and implement prevention programmes. These approaches should be evaluated to demonstrate the effectiveness of locally-led programming and make the case that this can lead to more successful prevention programmes.

In particular, there is a need for more organisational strengthening (e.g. finances, human resources) to support these organisations to be able to manage and access independent funding. Despite this, most capacity building projects focus on technical skills transfer to individuals, and wider organisational structures remain weak. When the individuals who participate in these programmes move on to other jobs and roles (often with international NGOs and the UN), the effects of the capacity building and strengthening efforts are diluted. New approaches are needed to build sustainability that focuses more holistically on the organisation and organisational processes. Without these efforts, localisation will remain a buzzword rather than a practical strategy.

While the lack of funding directed to CBOs and WROs remains a gap across all GBV programming in humanitarian settings, it particularly affects GBV prevention programmes where localisation is an essential component of programme design and delivery.



# Current funding modalities and programme cycles are misaligned and do not meet the specific needs of GBV prevention

## GAP TYPE



Systemic

## KEY THEMES



Lack of prioritisation and commitment



Limited funding

In humanitarian settings, funding is often prioritised to support risk mitigation and response work. These activities are typically discrete and are seemingly more applicable to short-term humanitarian programming cycles. However, this lack of prioritisation for funding prevention programming impacts the ability of organisations to implement effective, evidence-based GBV prevention programming.<sup>96</sup> As described by a respondent, “The biggest gaps are not in the programming for prevention but rather the funding modalities that support it. We have many prevention programming modalities, but often lack the resources to implement long-term programs and to layer supportive intervention/programming modalities with each other. We are often in search of the silver bullet, to make programs quicker, more cost effective, able to scale, but GBV prevention programs need time and resources”. In addition, the limited funding provided for prevention programming is often seen as tacked on as an afterthought to ‘GBV prevention and response’ programmes that are primarily response-focused.

This limited funding is not sufficient to implement the complex activities of a well-designed prevention programme.

Similarly, the short funding cycles typical in humanitarian programming are not set up to cater for the longer-term needs of prevention programming. Donors often lack an understanding about the implications of project cycles on what is feasible, especially taking into account the long-term nature of GBV prevention, which is inherently misaligned to short programme cycles (“Funding modalities in these settings are often short-term, and resources not invested in GBV prevention, yet are often expected by donors to be mainstreamed” – survey respondent). In particular, when a given crisis situation stabilises and moves beyond the acute phase, there is an opportunity to begin social norms change work. In settings such as refugee camps, for example, the population is generally stable and is likely to remain in displacement for many years (the average length of displacement for a refugee

remains about 20 years and more than 10 years for more than 90% of IDPs<sup>97</sup>). It is in these settings that there is a particular need to move beyond short-term funding cycles to better meet the needs of long-term change.

“The biggest gaps are not in the programming for prevention but rather the funding modalities that support it.”

Survey Respondent

## Lack of understanding and capacity to ensure prevention programming is built on evidence-based behaviour change theory, and addresses social norms change at institutional and systemic levels

### GAP TYPE



Operational



Systemic

### KEY THEMES



Weak capacity



Limited programming / interventions

Changing behaviour and reducing rates of GBV are complex initiatives that require considerable skill and understanding of behaviour change theory as well as the existing evidence about what approaches have had success (and why) in humanitarian and non-humanitarian settings. However, prevention programmes in humanitarian settings are rarely designed based on evidence, or utilise a tested theoretical framework of change. Instead, many organisations describe programming models as “preventing and responding to GBV”, when further examination of their models shows that they are actually raising awareness about and responding to cases of GBV. While there is growing understanding that ‘increasing awareness’ will not result in reductions in violence, existing programme approaches are still typically small-scale and focus on individual behaviour change, rather than shifting wider social norms.

As described by a respondent, “Not that many organisations have training on tried-and-tested methodologies such as the SASA! approach, or men’s engagement methodologies, and so may tend to use standard messaging in an ad-hoc manner. Activities often focus on the individual and community level and less on institutions and systems. Where policy and legislative change is effected, there may be gaps in follow-through on implementation”.

These challenges may be partly due to gaps in knowledge and capacity – particularly of smaller organisations – in understanding how prevention programmes should be designed and implemented. While there have been some efforts to build more comprehensive, evidence-based prevention programming, these programmes are still limited to a few, more well-resourced NGOs and are not the norm within humanitarian settings.

Existing programme approaches are still typically small-scale and focus on individual behaviour change, rather than shifting wider social norms.

# Limited capacity to contextualise, adapt and scale existing evidence-based programming models

## GAP TYPE



Operational



Systemic

## KEY THEMES



Weak capacity



Limited programming / interventions



Limited funding

There has been a lack of rigorous evaluations of GBV prevention programmes in humanitarian settings, due to limited research funding and lack of prioritisation of the development of prevention models by all but a few NGOs. While evidence-based prevention programmes (i.e. programmes based on behaviour change theory which have at least one high-quality, impact evaluation demonstrating effectiveness) are few in number, some models have been evaluated and have demonstrated impact. For example, programmes such as **SASA!** and **EMAP** have been successful at reducing violence (though available evidence is often from more stable or development settings) and could be further utilised in humanitarian settings. Despite these available examples, humanitarian agencies often lack the skills and necessary technical support to take these existing models and adapt them effectively to their specific context (“Working models to prevent GBV are there, but lack resources and local adaptation” – survey respondent).

**More effort is needed to support practitioners to contextualise and adapt available evidence-based prevention approaches relevant to their setting.** Successful models, where cohorts of organisations learn together and receive sustained technical support throughout implementation (for example, **Raising Voices** and **The Prevention Collaborative**) have proven to be promising practices to improve the quality of GBV prevention programmes. However, these efforts remain limited in number and reach. Furthermore, prevention programming typically requires large-scale efforts to change community and society norms around gender and violence. In practice, existing prevention efforts in humanitarian settings are often small-scale and thus unable to impact community-level outcomes – such as social norms.

“Working models to prevent GBV are there, but lack resources and local adaptation.”

Survey Respondent

## Lack of attention to GBV experienced by adolescent girls

### GAP TYPE



Operational



Systemic

### KEY THEMES



Limited programming / interventions

Gender-based violence often begins early in a girl's life in humanitarian settings. For example, in one multi-country study of adolescent girls, more than half reported experiencing violence in the past 12 months.<sup>98</sup>

In order to effect change, we must have strategies that target girls and seek to prevent violence from an early age. While there have been considerable efforts to improve coordination and programming strategies between the GBV and Child Protection sub-sectors (see for example, the **Child and Adolescent Survivor Initiative**), adolescent girls are still often overlooked. In particular, few prevention programmes have been found to be effective at preventing violence within this age range.

**While programmes that specifically target adolescent girls can often increase self-efficacy, confidence, life skills, etc., their limited scope often means they do not have an impact on rates of violence themselves.**<sup>99</sup>

The majority of existing prevention programmes still need to be refined to ensure they consider adolescent girls (including considering forms of violence particularly relevant to adolescent girls - such as early marriage, female genital mutilation, and IPV). More still needs to be done to ensure that community-based social norms change and that prevention programmes include adolescent girls and boys in their programming and work to change wider norms about violence against adolescent girls.

In order to effect change, we must have strategies that target girls and seek to prevent violence from an early age.

# Insufficient support for international and national staff to recognise and address their internal biases around gender and power

## GAP TYPE



Systemic

## KEY THEMES



Weak capacity



Lack of prioritisation and commitment



Limited programming / interventions

Humanitarian staff (both national and international) come from gender inequitable societies themselves and these views may conscientiously or unconscientiously bias their work. As described by a respondent, “Often, our own staff have not yet processed the behaviour and attitude changes needed to understand and properly deliver prevention programming. It is then highly unlikely that they will have a major influence in communities if they are not engaged themselves in that long-term process”.

In development settings, programming models such as Raising Voice’s **Get Moving!** curriculum take a prevention-oriented approach to training, and focus on organisational culture change. Furthermore, new efforts such as the Paris School of Economics and partners’ work to address gender biases within humanitarian programming may inform our understanding of these biases, and enable us to explore means to overcome them.<sup>100</sup> However, work to support staff in recognising and examining their own biases in humanitarian settings remains limited.

Humanitarian staff (both national and international) come from gender inequitable societies themselves and these views may conscientiously or unconscientiously bias their work.

## Lack of specialised skills and resources to effectively implement GBV prevention programme

### GAP TYPE



Operational

### KEY THEMES



Weak capacity



Lack of prioritisation and commitment

Across many of these priorities has been a cross-cutting theme of the need for capacity building and skills strengthening. As noted, GBV prevention programmes are complex and often require different skill sets compared to GBV response or risk mitigation. Yet under-resourced GBV programmes often have limited available human resources and have staff working on all GBV-related activities. This leads to over-stretched staff who may not have specific expertise in the activities they are implementing (e.g. counselling a survivor is a different skill set to changing social norms around gender). This affects the implementation of GBV programming at all levels - from UN agencies to community-based organisations.

However, even at large and well-resourced organisations there are insufficient dedicated gender professionals with skill sets that match the specific programming they are implementing. For example, an evaluation of UNFPA's work found that only half of its country offices implementing GBV programming had a professional-level gender staff member.<sup>101</sup> Furthermore, existing staff lack opportunities to continuously build and strengthen their skills. While many capacity building and skills-transfer courses and modules (such as the aforementioned courses and the **Rosa platform**) exist, none of these are specifically focused on prevention work.

Even at large and well-resourced organisations there are insufficient dedicated gender professionals with skill sets that match the specific programming they are implementing.

## Lack of prevention capacity for acute emergencies and knowledge of how to lay the groundwork for GBV prevention as the situation stabilises

### GAP TYPE



Operational

### KEY THEMES



Limited programming / interventions

There is often a debate about the practicality and utility of undertaking GBV prevention work in acute emergencies. However, the importance of engaging in this work has been reflected in the new **GBV Minimum Standards** (Standard 13: Transforming Systems and Social Norms), suggesting emerging agreement that some prevention work is a minimum requirement of GBV programming in emergencies.

While full, long-term social norms change programmes are often not practical during acute emergencies, stepped approaches that involve laying the groundwork and planning for longer-term prevention activities would be possible in these settings. For example, within reproductive health, the fifth objective of the MISP, which guides reproductive health activities during an emergency situation, is to plan for comprehensive reproductive health services.<sup>102</sup> Likewise, while a complete

prevention programme may not be practical in the acute stages of an emergency, longer-term prevention work can be planned for and the groundwork set up to implement as the situation stabilises. As described by a respondent, "Prevention programmes that can be adapted quickly at the onset of a humanitarian response are key (sometimes we are waiting so long that a crucial window of opportunity passes)".

While these approaches will not go as far as achieving the objective of reducing rates of GBV, they can serve as stepping stones that can help address the current lack of comprehensive prevention efforts as a given situation moves from either acute emergency to protracted crisis or early recovery.

While full, long-term social norms change programmes are often not practical during acute emergencies, stepped approaches that involve laying the groundwork and planning for longer-term prevention activities would be possible in these settings.



PRIORITY GAPS  
TABLE

# RISK MITIGATION

PRIORITY GAPS	SUMMARY OF THE GAPS	WHAT'S NEEDED		
		CREATE NEW STRATEGIES	BUILD ON EXISTING STRATEGIES	NEED FURTHER EVIDENCE
<p><b>1. Women and girls insufficiently engaged when identifying risks, developing mitigation plans, and monitoring implementation</b></p> 	<p>Existing risk mitigation activities (e.g. the identification of risks) do not fully involve women and girls in the development of mitigation activities and monitoring their implementation. While there are examples of good practice in engaging women and girls throughout both the risk identification and mitigation processes, these remain limited and there is a need to build upon these efforts to create new opportunities for the engagement of women and girls throughout the programming cycle.</p>			
<p><b>2. Lack of community ownership of risk mitigation activities</b></p> 	<p>Centring women and girls is important for ownership of risk mitigation activities. However, on their own, women and girls often lack the power to mitigate the risks they experience. More efforts are needed to create opportunities for community ownership in risk mitigation activities.</p>			
<p><b>3. Lack of evidence to understand the impact of risk mitigation activities</b></p> 	<p>While many organisations engage in some form of risk mitigation activities, the existing evidence base examining whether these activities are actually reducing the risk of violence is very weak. Data to measure safety and to understand the impact of risk mitigation activities is often not collected. While there have been limited evaluations, the quality of the research methods utilised to document the impact of risk mitigation activities is generally poor.</p>			

### GAP TYPE

-  Operational
-  Systemic

### KEY THEMES

-  Lack of accountability
-  Lack of evidence
-  Limited community participation
-  Lack of prioritisation and commitment
-  Limited funding
-  Limited programming / interventions
-  Weak capacity

# RISK MITIGATION

PRIORITY GAPS	SUMMARY OF THE GAPS	WHAT'S NEEDED		
		CREATE NEW STRATEGIES	BUILD ON EXISTING STRATEGIES	NEED FURTHER EVIDENCE
<p><b>4.</b> <b>Lack of commitment across all sectors to implement and prioritise GBV mitigation activities</b></p> 	<p>Despite considerable efforts from the GBV sub-sector, there remains a perception that GBV risk mitigation activities are separate from the core responsibilities of other sectors. Further effort is needed to change behaviours and norms stemming from gender biases within all sectors and to support these groups to prioritise GBV risk mitigation activities.</p>			
<p><b>5.</b> <b>Lack of accountability to ensure GBV mitigation activities are prioritised</b></p> 	<p>The lack of oversight and accountability mechanisms (e.g. tying risk mitigation activities to job performance, including tracking of activities such as safety audits as part of the management activities of organisations' senior leadership teams) has significantly contributed to the overall low accountability at all levels of the humanitarian system to mitigate GBV risks. This gap is also reflected in limited donor engagement in ensuring accountability.</p>			
<p><b>6.</b> <b>Lack of comprehensive, systematic and flexible funding to implement risk mitigation activities</b></p> 	<p>For many organisations, funds for GBV risk mitigation activities end at the risk identification stage (e.g. implementing safety audits) and do not include discretionary funding that will allow the organisation to make changes to reduce the risks identified. The lack of systematic, consistent and flexible funding limits humanitarian organisations' ability to mitigate identified risks.</p>			

### GAP TYPE

-  Operational
-  Systemic

### KEY THEMES

-  Lack of accountability
-  Lack of evidence
-  Limited community participation
-  Lack of prioritisation and commitment
-  Limited funding
-  Limited programming / interventions
-  Weak capacity

## RISK MITIGATION

PRIORITY GAPS	SUMMARY OF THE GAPS	WHAT'S NEEDED		
		CREATE NEW STRATEGIES	BUILD ON EXISTING STRATEGIES	NEED FURTHER EVIDENCE
<p><b>7.</b> <b>Lack of knowledge and support to operationalise/implement risk mitigation activities, especially for non-GBV specialists</b></p>  	<p>One of the strengths of the current GBV risk mitigation approach is the effort to mainstream mitigation activities and make reducing risks a core aspect of 'implementing good programming', rather than an extra task. However, the effect of this approach is that many practitioners from other sectors with no gender or GBV background (and often with their own patriarchal views on gender, violence, etc.) are charged with identifying and mitigating GBV risks. In many cases, they lack the ability to effectively identify GBV risks and implement risk mitigation.</p>			
<p><b>8.</b> <b>Lack of programming models to reduce risks where there are access limitations or where women cannot move freely</b></p>  	<p>Risk mitigation programmes emerged from traditional humanitarian response settings (e.g. refugee or IDP camps) and, as such, are typically designed for locations that are accessible - where it is much easier to identify risks and implement mitigation strategies. In addition, risk mitigation projects are often only focused on prioritising risk reduction within the wider community and rarely consider household-level risks, which may increase in particular in areas where women have limited freedom of movement and in public health emergencies.</p>			

### GAP TYPE

-  Operational
-  Systemic

### KEY THEMES

-  Lack of accountability
-  Lack of evidence
-  Limited community participation
-  Lack of prioritisation and commitment
-  Limited funding
-  Limited programming / interventions
-  Weak capacity

RESPONSE				
PRIORITY GAPS	SUMMARY OF THE GAPS	WHAT'S NEEDED		
		CREATE NEW STRATEGIES	BUILD ON EXISTING STRATEGIES	NEED FURTHER EVIDENCE
<p><b>1.</b> <b>Lack of sustained support for those providing essential PSS and GBV case management services</b></p>  	<p>In humanitarian settings, case managers may have limited training, and even those staff with advanced qualifications may not have had academic training in, or on-the-job experience of, working with survivors of GBV. This can impact the quality of case management support. In addition, case managers often need to balance PSS services with a myriad of other responsibilities, which can result in weak psychosocial programming, or in the prioritisation of other activities which may limit how effective psychosocial activities are in improving survivor wellbeing.</p>			
<p><b>2.</b> <b>The health sector needs better support to provide immediate CMR services and support for survivors of IPV</b></p>     	<p>While guidance and procedures are available to support the health sector so that facility staff can provide care to survivors of sexual violence and IPV, there is often a gap between these procedures and implementation. Further efforts are needed to ensure that available trainings and support packages translate into improved service delivery. In addition, more consideration needs to be given to possible approaches to strengthen health support for survivors and to break down barriers to reporting violence within these settings.</p>			

**GAP TYPE**

-  Operational
-  Systemic

**KEY THEMES**

-  Lack of accountability
-  Lack of evidence
-  Limited community participation
-  Lack of prioritisation and commitment
-  Limited funding
-  Limited programming / interventions
-  Weak capacity

RESPONSE				
PRIORITY GAPS	SUMMARY OF THE GAPS	WHAT'S NEEDED		
		CREATE NEW STRATEGIES	BUILD ON EXISTING STRATEGIES	NEED FURTHER EVIDENCE
<p><b>3.</b> <b>Insufficient integration of financial support/ livelihoods components into support programming for survivors</b></p> 	<p>While women and girls in humanitarian settings consistently face the challenges of poverty, GBV survivors are often particularly impacted. As well as dealing with the trauma of their violent experience, they must also contend with the daily stress of poverty and the inability to provide for their families.</p> <p>In humanitarian contexts, it can be especially difficult to address psychological issues (e.g. depression, PTSD) without also addressing these practical concerns. However, when cash transfer or livelihood programmes are integrated with GBV services the quality may be mixed or may not achieve the expected outcomes.</p>			
<p><b>4.</b> <b>Safe access to health services for adolescent survivors of GBV</b></p> 	<p>Existing adolescent-friendly SRH approaches lack fully integrated support for GBV survivors and typically do not prioritise support for girls experiencing IPV.</p>			

**GAP TYPE**

-  Operational
-  Systemic

**KEY THEMES**

-  Lack of accountability
-  Lack of evidence
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-  Limited programming / interventions
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RESPONSE				
PRIORITY GAPS	SUMMARY OF THE GAPS	WHAT'S NEEDED		
		CREATE NEW STRATEGIES	BUILD ON EXISTING STRATEGIES	NEED FURTHER EVIDENCE
<p><b>5.</b> <b>Lack of coverage of, safe access to, and effective programming within shelters/safe houses for survivors</b></p> 	<p>Some women and girls experiencing violence in humanitarian settings want to leave their existing situation – either temporarily or permanently. In camp settings, limited shelters are usually available through the UN or INGOs, though these facilities often do not have enough capacity to meet the caseload. In addition, these structures may be stigmatising for women and girls seeking support and it may be a difficult/bureaucratic process to access them/be relocated to another camp or location for long-term safety.</p> <p>A lack of practical exit strategies for survivors (e.g. resettlement in another camp), whether temporary or permanent, results in survivors staying in these facilities for extended periods, prolonging instability in their lives and reducing the ability of these systems to absorb more cases.</p>			
<p><b>6.</b> <b>Limited understanding of and support for informal, community-based services for survivors</b></p> 	<p>Women and girls who experience violence may disclose their experience and/or seek support through informal networks rather than disclosing to a formal service provider. Existing programming is often not designed to guide informal actors and structures to support survivors. Furthermore, the humanitarian community does not fully understand the ways in which communities provide support, and how to structure programmes that do not empower existing patriarchal structures that disadvantage women and girls who seek help through informal channels.</p>			

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PRIORITY GAPS	SUMMARY OF THE GAPS	WHAT'S NEEDED		
		CREATE NEW STRATEGIES	BUILD ON EXISTING STRATEGIES	NEED FURTHER EVIDENCE
<p><b>7.</b> <b>Lack of knowledge on the long-term impact of PSS for survivors</b></p> 	<p>Efforts to understand PSS outcomes primarily focus on assessing improvement on psychological indicators throughout and/or at the end of an intervention. While some follow-up studies have begun, there is a lack of long-term follow-up to see if these programmes have a lasting effect on the mental health or wellbeing of women and girls who experience violence.</p>			
<p><b>8.</b> <b>Lack of coverage and survivor-centeredness of formal and informal legal and justice services, especially in remote locations</b></p> 	<p>Formal legal actors often hold patriarchal attitudes, and available services are not survivor-centred; for example, there can be a lack of privacy and confidentiality. Similarly, where informal justice systems fill the gaps in coverage of formal justice, these systems are often patriarchal, rely on mediation practices, and are not set up to support survivors. Both coverage and services that are survivor-centred remain a gap for both the formal and informal systems.</p>			

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<p><b>9.</b> <b>Lack of effective support for police to provide quality, survivor-centred services</b></p> 	<p>While some efforts – the establishment of gender desks/units or similar structures – have been implemented in humanitarian settings, these efforts are often limited and turnover of staff or lack of commitment at higher levels affect these efforts. Police and the wider legal structure are often patriarchal structures in and of themselves. Considerable effort is required to create social norms change within these structures to promote more ethical and survivor-centred care for survivors.</p>			
<p><b>10.</b> <b>Limited capacity to provide case management services during disease outbreak or where women cannot move freely</b></p> 	<p>Women do not stop needing GBV response services during public health emergencies or in situations where they are not able to move freely, however, traditional case management services require face-to-face interaction and support. While models utilising phone or internet-based services have been piloted, they are not yet commonly utilised as standardised options for women in humanitarian crisis. In addition, in situations where it is not safe or possible for women to use a phone or mobile platform, even more creative ways to reach women and girls are needed.</p>			

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# PREVENTION

PRIORITY GAPS	SUMMARY OF THE GAPS	WHAT'S NEEDED		
		CREATE NEW STRATEGIES	BUILD ON EXISTING STRATEGIES	NEED FURTHER EVIDENCE
<p><b>1. Insufficient support for CBOS/WROs to develop and lead locally-designed prevention programmes</b></p> 	<p>Despite global promises to increase the localisation of aid, locally-based organisations (including national NGOs and CBOs) are still often marginalised. While the lack of funding directed to CBOs and WROs remains a gap across all GBV programming in humanitarian settings, it particularly affects GBV prevention programmes where localisation is an essential component of programme design and delivery. More efforts are needed to operationalise the localisation agenda and shift the power to locally-based organisations to design and implement prevention programmes.</p>			
<p><b>2. Current funding modalities and programme cycles are misaligned and do not meet the specific needs of GBV prevention</b></p> 	<p>The limited funding that exists is not sufficient to implement the complex activities of a well-designed prevention programme. Particularly in protracted crises, there is a need to move beyond short-term funding cycles and invest in long-term change.</p>			

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# PREVENTION

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		CREATE NEW STRATEGIES	BUILD ON EXISTING STRATEGIES	NEED FURTHER EVIDENCE
<p><b>3.</b></p> <p><b>Lack of understanding and capacity to ensure prevention programming is built on evidence-based behaviour-change theory, and addresses social norms change at institutional and systemic levels</b></p> 	<p>There are gaps in knowledge and capacity – particularly of smaller organisations – in understanding how prevention programmes should be designed and implemented. While there have been some efforts to build more comprehensive, evidence-based prevention programming, these programmes are still limited to a few, more well-resourced NGOs and are not the norm within humanitarian settings.</p>			
<p><b>4.</b></p> <p><b>Limited capacity to contextualise, adapt and scale existing evidence-based programming models</b></p> 	<p>Humanitarian agencies often lack the skills and necessary technical support to take existing prevention models and adapt them effectively to their specific context. Furthermore, prevention programming typically requires large-scale efforts to change community and society norms around gender and violence. In practice, existing prevention efforts in humanitarian settings are often small-scale and unable to impact community-level outcomes – such as social norms.</p>			

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# PREVENTION

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<p><b>5.</b> <b>Lack of attention to GBV experienced by adolescent girls</b></p> 	<p>While there have been considerable efforts to improve coordination and programming strategies between the GBV and Child Protection sub-sectors, adolescent girls are still often overlooked. In particular, few prevention programmes have been found to be effective at preventing violence within this age range. The majority of existing prevention programmes still need to be refined to ensure they consider adolescent girls (including considering forms of violence particularly relevant to adolescent girls, such as early marriage, female genital mutilation, IPV, etc.).</p>			
<p><b>6.</b> <b>Insufficient support for international and national staff to recognise and address their internal biases around gender and power</b></p> 	<p>Humanitarian staff come from gender inequitable societies themselves, and associated views may conscientiously or unconscientiously bias their work. Work to support national and international staff to recognise and examine their own biases in humanitarian settings remains limited.</p>			

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# PREVENTION

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		CREATE NEW STRATEGIES	BUILD ON EXISTING STRATEGIES	NEED FURTHER EVIDENCE
<p><b>7.</b> <b>Lack of specialised skills and resources to effectively implement GBV prevention programmes</b></p> 	<p>Whether for under-resourced GBV programmes or within well-resourced organisations, there are insufficient dedicated gender professionals with skill sets that match the specific programming they are implementing. While many capacity building and skills-transfer courses and modules exist, none of these are specifically focused on prevention work.</p>			
<p><b>8.</b> <b>Lack of prevention capacity for acute emergencies and knowledge of how to lay the groundwork for GBV prevention as the situation stabilises</b></p> 	<p>While full, long-term social norms change programmes or a complete GBV prevention programme may not be practical in the acute stages of an emergency, longer-term prevention work can be planned for, and the groundwork set up to implement it, as the situation stabilises.</p>			

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### KEY THEMES

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The image features a dark blue background with a central white text element. The word "CONCLUSIONS" is written in a clean, white, sans-serif font. Surrounding this central text are several abstract, colorful lines in shades of teal, orange, and purple. These lines are styled as thick, rounded strokes that curve and loop around the text, creating a sense of movement and depth. Some lines are solid, while others are dotted. The overall composition is modern and minimalist, with a focus on geometric shapes and vibrant colors.

CONCLUSIONS

## CONCLUSIONS

Overall, there has been considerable work invested in mitigating the risks of GBV, responding to cases and preventing violence. However, gaps remain and the needs facing the sector are vast – particularly given the increases in GBV due to the COVID-19 pandemic and increasing pressures on already limited resources to respond to this health crisis.

At the highest level, there is a lack of prioritisation, commitment and accountability throughout the humanitarian sector. Other sectors do not prioritise integrating GBV risk mitigation activities into their own work, and there are few accountability mechanisms to ensure this essential work is implemented effectively. Likewise, GBV prevention activities are not often prioritised, even within the humanitarian sector, and there are few initiatives that seek to address gender and power imbalances within humanitarian organisations and the sector at large. Lack of funding is also a consistent challenge for GBV risk mitigation, response and prevention programming.

Gaps remain and the needs facing the sector are vast – particularly given the increases in GBV due to the COVID-19 pandemic.

## CONCLUSIONS

Beyond these issues, a lack of capacity and accessible support mechanisms are also a challenge facing staff in the sector. Non-GBV specialists are tasked with mitigating GBV risks, yet often do not have the appropriate support or capacity to engage in these activities. Gender-based violence specialists are often over-stretched and asked to deliver high-quality prevention and response activities with access to only limited resources and training. In addition, effective programming approaches are, in some cases, lacking – particularly when considering specific sub-populations (e.g. adolescent girls), or working with governmental (e.g. police, courts, health systems) or informal institutions that are outside the international humanitarian system itself. These weak programming approaches limit the effectiveness of GBV response and prevention activities. Furthermore, overall, the sector suffers from limited evidence demonstrating the effectiveness of the implemented

approaches. More research, improved M&E and better use of existing data are all needed to improve the effectiveness of existing programming and to help inform new efforts to tackle these challenges.

Many of the challenges facing the GBV sector, as well as the wider humanitarian system, are systemic in nature. This report has sought to draw out not only specific operational programming gaps, but also to reflect on these wider systemic issues. Operational gaps may be seen as 'low-hanging fruit', as addressing these deficiencies may require a more discrete intervention (e.g. developing a new programming model, or creating a new capacity building training programme). However, it should be remembered that these operational gaps are often a result of wider systemic challenges. For example, GBV staff may have short-term contracts due to short funding cycles, which limits opportunities for capacity development and risks the loss of

knowledge when staff members leave the organisation because of the insecurity of their position.

Similarly, the lack of funding for GBV programmes limits the ability of an organisation to appropriately resource an intervention. De-prioritisation of risk mitigation activities by other sectors means that the developed tools and guidance to support these efforts are operationalised inconsistently. This does not mean that operational gaps should not be addressed by the humanitarian community, but it does suggest that specific acknowledgement of the wider systemic constraints is required when developing new solutions to address these gaps. It also points to the need for parallel processes that advocate for wider change within the humanitarian aid system that will facilitate lasting operational improvements.

While considerable work has been done to raise the profile of GBV and to change perspectives so that mitigating risks and linking survivors to services are seen as 'everyone's work', underlying inequitable power dynamics and patriarchal attitudes that run throughout the humanitarian aid system remain major barriers to the prioritisation of GBV activities.

# CONCLUSIONS

Given the current global economic climate resulting from the pandemic, it seems likely that funding for humanitarian settings will, at best, stay stagnant, or more likely decline in the coming years. Responders and policymakers will need to continue to advocate for funding dedicated to GBV within this context.

Positively, the **GBV AoR** and other global stakeholders have consistently advocated to draw attention to the issue of GBV during humanitarian crisis and have had considerable success in helping prioritise the issue as a life-saving aspect of humanitarian response. They have also created a vast library of guidelines and support documents that are primed to help actors improve their programming in a variety of settings.<sup>103</sup> Key global initiatives (including IMC's **Managing Gender-Based Violence in Emergencies Global Learning Programme**, and the Rosa platform are providing trainings to build capacity, and the **AoR's Helpdesk** is providing targeted support to synthesise global best practice. Initiatives such as **RTAP** are seeking to address accountability issues within humanitarian practice, and efforts such as **Building Local, Thinking Global** are working to centre women's organisations in the humanitarian space.

New programming models that seek to engage adolescent girls or to expand GBV response capabilities and coverage are continually emerging. The work of these, and the many initiatives documented throughout this report, should be learned from and built upon. However, more support is needed to operationalise and build the capacity of organisations to deliver effective programmes. More long-term and stable funding is needed to build consistency and to support a steady workforce on the front lines that can be invested in.

**Despite these challenges, there are reasons – including the many promising practices and initiatives identified in this report - to be hopeful.** While this report only briefly touches on issues of SEA, the issues being brought to light through the #AidToo movement, as well as wider efforts to recognise systematic racism and inequalities globally, are clearly linked to the work of the GBV community to raise awareness and address the situation facing women and girls. Hopefully, these efforts will continue to build momentum and lead to change within aid systems and to the development of more robust and transparent accountability structures – not just to practitioners, researchers, donors and innovators - but to women and girls themselves.

We are confident that, by highlighting some of the most pressing gaps that affect the wider humanitarian community's ability to effectively address GBV, this Gap Analysis provides direction for future priorities in humanitarian settings.

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**2)** [Global and regional estimates of violence against women](#)

**3)** [A systematic review of prevalence studies of gender-based violence in complex emergencies](#)

[No Safe Place: A Lifetime of Violence for Conflict-affected Women and Girls in South Sudan](#)

[From political to personal violence: Links between conflict and non-partner physical violence in post-conflict Liberia](#)

[The effects of conflict and displacement on violence against adolescent girls in South Sudan: the case of adolescent girls in the Protection of Civilian sites in Juba](#)

[Sex trafficking and sexual exploitation in settings affected by armed conflicts in Africa, Asia and the Middle East: systematic review](#)

**4)** [A systematic review of prevalence studies of gender-based violence in complex emergencies](#)

**5)** [A systematic review of prevalence studies of gender-based violence in complex emergencies](#)

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**7)** [Converging drivers of interpersonal violence: Findings from a qualitative study in post-hurricane Haiti](#)

**8)** [Violence Against Women and Natural Disasters: Findings From Post-Tsunami Sri Lanka](#)

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**10)** [Children's Ebola Recovery Assessment: Sierra Leone](#)

[Ebola vaccine offered in exchange for sex, Congo taskforce meeting told](#)

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**12)** [The effects of conflict and displacement on violence against adolescent girls in South Sudan: the case of adolescent girls in the Protection of Civilian sites in Juba](#)

["To protect her honour": Child marriage in emergencies – the fatal confusion between protecting girls and sexual violence](#)

**13)** Survivor-centred refers to an approach that 'aims to create a supportive environment in which each survivor's rights are respected and in which the person is treated with dignity and respect'. - [Interagency Gender-Based Violence Case Management Guidelines](#)

## PAGE 13 . METHODOLOGY

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**14)** [Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action](#)

**15)** The following sources were specifically searched: Pubmed; PsycINFO; Scopus; Global Health; Reliefweb; Humanitarianresponse.info; SVRI; Gbvaor.net; Iawg.net; What Works to Prevent Violence against Women and Girls Evidence Hub;

Prevention Collaborative Knowledge Platform; GBV Prevention Network; UN Women's Global Knowledge Platform to End Violence against Women; ALNAP; and GBV Responders. In addition, Google searches for GBV programmes and evaluations were undertaken.

## PAGE 14 . METHODOLOGY

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**16)** A consensus-building technique that has been used to develop global consensus around other topics in the humanitarian field. See [Ethical considerations for children's participation in data collection activities during humanitarian emergencies: A Delphi review](#) as an example.

**17)** [A pragmatist approach to the problem of knowledge in health psychology](#)

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**20)** [Checklist on incorporating Protection and Accountability to Affected Populations in the Humanitarian Programme Cycle](#)

**21)** [Where is the Money? How the Humanitarian System is Failing in its Commitments to End Violence Against Women and Girls](#)

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**29)** [Do Solar Lights Improve Protection?](#)

**30)** [Do Solar Lights Improve Protection?](#)

**31)** [Shining a Light: How lighting in or around sanitation facilities affects the risk of gender-based violence in camps](#)

**32)** [Improving safety for women and girls. GBV risk mitigation in humanitarian response: practical examples from multiple field settings](#)

**33)** [Lighting the way: The role of handheld solar lamps in improving women's and girl's perceptions of safety in two camps for internally displaced people in Haiti](#)

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**34)** [Cash Transfers in Raqqa Governorate, Syria: Changes Over Time in Women's Experiences of Violence & Wellbeing](#)

**35)** [Empowered Aid: Reducing Risks of Sexual Exploitation and Abuse in Cash Assistance](#)

**36)** [Empowered Aid: Reducing Risks of Sexual Exploitation and Abuse in Cash Assistance](#)

**37)** [Empowered Aid: Participatory Action Research Workshops Curriculum and Facilitation Guide](#)

**38)** [Empowered Aid: Participatory Action Research Toolkit](#)

**39)** [Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action](#)

**40)** [No Simple Solutions: Women, Displacement and Durable Solutions in South Sudan](#)

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**43)** [Interagency Gender-Based Violence Case Management Guidelines](#)

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**44)** [Nigeria: Gender Based Violence Sub Sector: Partner Presence by Type and Service Provided; June 2019](#)

**45)** [South Sudan Humanitarian Needs Overview 2020 \(November 2019\)](#)

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**47)** [Violence, uncertainty, and resilience among refugee women and community workers: An evaluation of gender-based violence case management services in the Dadaab refugee camps](#)

**50)** [Guidelines for Mobile and Remote Gender-Based Violence \(GBV\) Service Delivery](#)

**48)** [Reaching Refugee Survivors of Gender-Based Violence: Evaluation of a Mobile Approach to Service Delivery in Lebanon](#)

**51)** [Evaluation of the Gender Based Violence Information Management System \(GBVIMS\)](#)

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**55)** [Reducing psychological distress in refugee survivors of gender-based violence: adaptation and pilot of a WHO guided self-help intervention with South Sudanese refugees in Uganda](#)

**54)** [Meeting the Sexual and Reproductive Health Needs of Adolescent Girls in Humanitarian Settings SVRI Conference 2019](#)

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**56)** [Sexual and gender-based violence in areas of armed conflict: a systematic review of mental health and psychosocial support interventions](#)

**57)** [Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence](#)

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**58)** [Integrating sexual and reproductive health services with GBV response in Northwest Syria](#)

**60)** [Integrating sexual and reproductive health services with GBV response in Northwest Syria](#)

[Strengthening Health Services For Gender-Based Violence Survivors in Emergencies](#)

[Challenging Gender-based Violence Worldwide: CARE's Program Evidence](#)

[Unicef Evaluation Report. Child Protection Section Programme Division 2016](#)

**61)** [Comprehensive development and testing of the ASIST-GBV, a screening tool for responding to gender-based violence among women in humanitarian settings](#)

**59)** [Systematic review of the evidence on the effectiveness of sexual and reproductive health interventions in humanitarian crises](#)

[An evidence review of research on health interventions in humanitarian crises](#)

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**62)** See also the Hargeisa Central Hospital in Somaliland, which now has a Sexual Assault and Referral Centre; and Family Centre Somalia

**64)** [Community-based Medical Care for Survivors of Sexual Assault: Building the Evidence](#)

**63)** [Prevention of violence against women and girls: what does the evidence say?](#)

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**66)** [Gender training for police peacekeepers: Approaching two decades of United Nations Security Council Resolution 1325](#)

**67)** [Ten-year Impact Study on Implementation of UN Security Council Resolution 1325 \(2000\) on Women, Peace and Security in Peacekeeping](#)

**68)** [Intersections of violence against women and girls with state-building and peace-building: Lessons from Nepal, Sierra Leone and South Sudan](#)

**69)** [Gender training for police peacekeepers: Approaching two decades of United Nations Security Council Resolution 1325](#)

**70)** [Safe Haven. Sheltering Displaced Persons from Sexual and Gender-Based Violence. Case Study: Kenya](#)

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**73)** [Exploring the Intersection of Violence Against Women and Girls With Post-Conflict Statebuilding and Peacebuilding Processes: A New Analytical Framework](#)

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**74)** For example: [SASA!; Stepping Stones and Creating Futures intervention: shortened interrupted time series evaluation of a behavioural and structural health promotion and violence prevention intervention for young people in informal settlements in Durban, South Africa](#)

[Community activism as a strategy to reduce intimate partner violence \(IPV\) in rural Rwanda: Results of a community randomised trial](#)

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[Living Peace in Democratic Republic of the Congo: An Impact Evaluation of an Intervention with Male Partners of Women Survivors of Conflict-Related Rape and Intimate Partner Violence](#)

**76)** [Sustained Effectiveness of the Communities Care Program to Change Social Norms about Gender-based Violence in Somalia and South Sudan](#)

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**79)** [Economic and Social Empowerment to Reduce Violence against Women](#)

**80)** [A Safe Place to Shine: Creating Opportunities and Raising Voices of Adolescent Girls in Humanitarian Settings](#)

[Preventing violence against refugee adolescent girls: findings from a cluster randomised controlled trial in Ethiopia](#)

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**81)** [What works to prevent violence against children in Afghanistan? Findings of an interrupted time series evaluation of a school-based peace education and community social norms change intervention in Afghanistan](#)

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**84)** [Call to Action on Protection from Gender-based Violence in Emergencies. Road Map 2016-2020](#)

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**85)** [Real-Time Accountability Partnership](#)

**86)** [GBV Accountability Framework: Advancing Action on Protection from GBV in Emergencies](#)

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**91)** [A forgotten group during humanitarian crises: a systematic review of sexual and reproductive health interventions for young people including adolescents in humanitarian settings](#)

[Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings](#)

## PAGE 59 . PRIORITY GAPS

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**92)** [Nowhere to go: disclosure and help-seeking behaviors for survivors of violence against women and girls in South Sudan](#)

**93)** [Navigating support, resilience, and care: Exploring the impact of informal social networks on the rehabilitation and care of young female survivors of sexual violence in northern Uganda](#)

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**94)** [Sexual and gender-based violence in areas of armed conflict: a systematic review of mental health and psychosocial support interventions](#)

[What works to prevent violence against women and girls in conflict and humanitarian crisis: Synthesis Brief](#)

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**95)** [Evidence brief: What works to prevent and respond to violence against women and girls in conflict and humanitarian settings?](#)

[Prevention of violence against women and girls: what does the evidence say?](#)

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**96)** We are not using a formal definition of 'evidence-based' for the purposes of this report. However, common methodologies such as GRADE (BMJ 2008;336:924), or other evidence quality metrics, have been applied to systematic reviews of evidence on GBV programming in humanitarian settings and all have found the evidence is generally of low quality. See for example, [What works to prevent violence against women and girls in conflict and humanitarian crisis: Synthesis Brief](#)

**97)** [Forced displacement: refugees, asylum-seekers and internally displaced people \(IDPs\)](#)

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**98)** [Prevalence and associated risk factors of violence against conflict-affected female adolescents: a multi-country, cross-sectional study](#)

**99)** [Girl Empower A Safe Place to Shine: Creating Opportunities and Raising Voices of Adolescent Girls in Humanitarian Settings](#)

## PAGE 70 . PRIORITY GAPS

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**100)** [Addressing Gender Bias Within Humanitarian Organisations and Gender-Based Violence in Emergencies Programming](#)

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**101)** [Evaluation of UNFPA support to the prevention of, response to and elimination of gender-based violence and harmful practices \(2012-2017\)](#)

## PAGE 72 . PRIORITY GAPS

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**102)** [Minimum Initial Service Package \(MISP\)](#)

## PAGE 89 . CONCLUSIONS

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**103)** See [GBV AoR Tools & Resources](#) and the [IASC Guidelines](#)

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